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ABSTRACT

This publication is a comprehensive record of testimony and exhibits presented to a subcommittee of the Committee on Appropriations of the U.S. Senate during hearings on 1977 budget requests for the Department of Health, Education, and Welfare (DHEW). The hearings transcribed here were held January 29-February 2, 1976 and concerned appropriations for the Center for Disease Control, Health Services Administration, Office of the Secretary (HEW), Office of the Assistant Secretary for Health, and retirement pay and medical benefits for commissioned officers. Primary spokesmen for DHEW at the hearings were Secretary David Mathews, Assistant Secretary for Health Theodore Cooper, and Associate Administrator for Operations John E. Marshall. Testimony and exhibits are indexed chronologically, by subject matter, and alphabetically by witnesses' names. (JG)

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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1977

HEARINGS

BEFORE A

SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS UNITED STATES SENATE

NINETY-FOURTH CONGRESS

SECOND SESSION

Printed for the use of the Committee on Appropriations

PART 2—(Pages 585–878)

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Center for Disease Control
Health Services Administration
Office of Assistant Secretary for Health
Office of the Secretary, HEW
Retirement Pay and Medical Benefits for Commissioned Officers

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DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1977

THURSDAY, JANUARY 29, 1976

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 2:05 p.m., in room S-128, the Capitol, Hon. Warren G. Magnuson (chairman) presiding.

Present: Senators Magnuson, Chiles, Brooke, and Schweiker.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF THE SECRETARY

STATEMENT OF HON. DAVID MATHEWS, SECRETARY

ACCOMPANIED BY:

JOHN D. YOUNG, ASSISTANT SECRETARY, COMPTROLLER
STEPHEN KURZMAN, ASSISTANT SECRETARY FOR LEGISLATION
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER

OPENING STATEMENT OF SENATOR MAGNUSON

Senator MAGNUSON. The subcommittee will come to order. We are pleased to welcome Secretary Mathews, who is appearing before the subcommittee for the first time.

This will be the first of several hearings we will hold on HEW. In the days ahead we will get into the specific programs. For the time being, Secretary Mathews will give us a brief overview of the budget.

This year the HEW budget totals $145 billion. The bulk of this amount, $103 billion, is in the social security trust funds.

You still persist in putting social security funds in the budget? They are not a part of the budget at all, and they are noncontrollable. You have nothing to do with them financially. The Congress determines the rules or the eligibility.

Secretary MATHEWS. That's right.

Senator MAGNUSON. But you still persist in doing that, and sometimes I think it is only for the reason to go out and say, "Oh, look

how much we're doing for the social needs of the country." Social security is an insurance. This doesn't come out of the budget, any part of it. It is in for safe keeping down there, but I don't know why you persist in putting this in the budget. There are many people involved in appropriations and the budgetary processes of the Budget Committee who are seriously thinking about establishing an independent commission to oversee social security, independent of HEW or the administration. You have no control over it whatsoever, moneywise.

But this has been going on for a long time. Now, there's no use for me to suggest that this is a complex, difficult budget, what's left of it, and it affects everybody in the country indirectly or directly, and before we get through, Mr. Secretary, we hear hundreds of witnesses, sometimes we have gone as high as 416, outsiders and departmental, and there are hundreds of line items in this bill.

So we'll go ahead and we'll start with your overall statement and we're going to have to ask more questions, specific questions of your subheads of different departments.

Secretary MATHEWS. Please feel free to interrupt and ask questions at any time.

OVERALL BUDGET FIGURES

My opening statement indicates that we both agree that overseeing this budget is a sizable responsibility. In outlay figures, the budget that we're bringing to you today is $140 billion, Mr. Chairman, which is up $12 billion from the 1976 budget.

Senator MAGNUSON. Well, let's start right there. What is the $12 billion increase?

Secretary MATHEWS. From the President's budget as brought to you last year.

Senator MAGNUSON. Is that social security? Here we go again.

Secretary MATHEWS. $3.7 billion of it isn't.

Senator MAGNUSON. So the President had nothing to say about that increase. That was a matter of law, noncontrollable items.

Secretary MATHEWS. Well, he did in his budget——

Senator MAGNUSON. You people make speeches about how you are up $3.7 billion but you had nothing to do with it.

Secretary MATHEWS. Well this time we did make some very specific recommendations about——

Senator MAGNUSON. Well, you can make recommendations to the Committee on Social Security, but it's not your money to begin with.

Secretary MATHEWS. But the portion of that budget that your committee is considering is $44.2 billion.

Senator MAGNUSON. There are some other items in here that you increased.

Secretary MATHEWS. Of the $12 billion increase in the total budget, $3.7 billion of that amount applies to the $44.2 that you are concerned about.

Senator MAGNUSON. There you've got it, the first page, we'll be considering $44.2 billion.

Secretary MATHEWS. Right, sir.

Senator MAGNUSON. That's all we can consider and all you can consider.

I don't know; you must have had a briefing before you started out.

Secretary MATHEWS. Well, I read the transcript from last year, Senator, and I gather we have what is called a difference of opinion on this matter, because the President——

Senator MAGNUSON. Well, let me ask you, do you think social security is part of the budget?

Secretary MATHEWS. Well, I can certainly see the President's reasons for putting——

Senator MAGNUSON. I'm not talking about the President's reasons.

Secretary MATHEWS. I am persuaded by them that they are sound.

Senator MAGNUSON. Are you persuaded by certain people here that it is part of the budget when you have no control over it? You have nothing to do with it.

Secretary MATHEWS. Only in the sense that it is affected by law, which in turn we may affect by recommendations to the Congress, which in fact we do propose to do at this time.

Senator MAGNUSON. All right. Then you go to the Legislative Committee and change it, the Finance Committee. They're the ones. You have nothing to do with it whatsoever.

Secretary MATHEWS. But we do make that statement because it relates to the overall budget ceiling.

Senator MAGNUSON. It has an indirect effect upon the Budget Committee which is looking at these ceilings.

Secretary MATHEWS. Right, sir.

Senator MAGNUSON. But it has no effect at all on your budget.

Secretary MATHEWS. Well, it is a matter which I have spent an enormous amount of time because I'm the administrator of the social security program.

Senator MAGNUSON. But you're Administrator according to law. You don't make any decisions about it.

Secretary MATHEWS. Only under law, but I guess that's what your committee——

Senator MAGNUSON. You don't make any dollar decisions on it.

Secretary MATHEWS. Only in the sense that we might write some legislation or purpose——

Senator MAGNUSON. But that's got nothing to do with the appropriations. That's a different story.

Secretary MATHEWS. Our position is, as you would anticipate, that the $140 billion figure is what we report as our Department's budget, but we are here today to discuss $44.2 billion.

Senator MAGNUSON. It's somebody else's money that you're fixing up for everybody.

Secretary MATHEWS. Well, we try to give them credit for it and give it back to them.

Senator MAGNUSON. Let's get down to what you have got some control over, $44.2 billion.

Secretary MATHEWS. Right. If we go to paragraph 2——

Senator MAGNUSON. Well, let's get this into perspective because it's timely. Yesterday we overrode the President's veto on Health and

Welfare. Education was not involved in this. That bill totaled $36 billion. But we were under the 1975 appropriation by $7.117 billion.

Secretary MATHEWS. Yes.

Senator MAGNUSON. Now, you are coming here and you are talking about $44 billion. Now, are we up that much from this bill?

Secretary MATHEWS. I don't believe the categories are exactly the same.

Senator MAGNUSON. So the record will be clear, you're talking about outlays.

Secretary MATHEWS. Our figures are all outlays.

Senator MAGNUSON. So the record will be clear on that. All right.

Secretary MATHEWS. And the $4 billion is budget authority, and the proposed legislation——

Senator MAGNUSON. All right. Now, right there you claim this is $3.7 billion more than 1976, right? Is that correct?

Secretary MATHEWS. Right, sir.

Senator MAGNUSON. Of the categories you have to do something with.

Secretary MATHEWS. Right, sir.

Senator MAGNUSON. All right, go right ahead.

THE 1977 BUDGET

Secretary MATHEWS. That totals roughly 35 percent of the entire Federal budget as over 34 percent of the total last year.

Senator MAGNUSON. Well, there we go, there we go.

Secretary MATHEWS. Well, you're going to like page 2, Senator. [General laughter.]

Senator MAGNUSON. By law you have nothing to do with 34 percent.

CONTROLLABLE VERSUS NON-CONTROLLABLE FUNDS

Secretary MATHEWS Of this amount, 97 percent is, to all intents and purposes, not controllable through the annual appropriation process. In this category we include——

Senator MAGNUSON. Now we're getting down to it.

Secretary MATHEWS. I told you you'd like it.

We include such outlays as social security benefits, which are spent from trust funds, and cash welfare payments which you do appropriate annually, but which are determined by amounts due to beneficiaries and are not really subject to your choice or ours. This is not to say that nothing can be done about spending levels for these programs.

PROPOSED LEGISLATION

The proposed legislation now. Of major importance in the President's budget——

Senator MAGNUSON. All right, now, wait a minute, wait a minute. We're not a legislative committee.

Secretary MATHEWS. Right, sir.

Senator MAGNUSON. Now, why this dialogue about legislation?

Secretary MATHEWS. If you would like, I would be delighted to skip that section.

Senator MAGNUSON. We heard about that last week.

Secretary MATHEWS. That will move us over to——

Senator MAGNUSON. You're making a plea here for legislation. I agree with you on some of it. I'll vote for it.

But we're a money committee. We're not a legislative committee.

BLOCK GRANTS

Secretary MATHEWS. The block grants are items that might interest you. We will include those in my oral comments now, or leave them?

Senator MAGNUSON. Go right ahead, go right ahead. Unless the Senator from Pennsylvania has some questions.

Senator SCHWEIKER. Block grants affect our appropriations, right?

Senator MAGNUSON. Oh, yes. Now they're talking about appropriations.

Senator SCHWEIKER. We ought to hear that.

Secretary MATHEWS. You are already, I think, quite familiar with the fact that one of the major proposals that we are making is to consolidate, through legislation, 45 of the Department's programs in separate block grants for education, health, and social services.

These consolidations will gives States and local governments greater flexibility in determining funding priorities; simplify program administration at both Federal and State levels; eliminate existing inequities in Federal funding; focus Federal resources on the poorest and most disadvantaged; and eliminate required State matching.

The Financial Assistance for Health Care Act consolidates 16 Public Health Service, medicaid and developmental disabilities programs into a new $10 billion health service grant to the States. Legislation would provide for a $10.5 billion authorization level in fiscal year 1978 and $11.0 billion in fiscal year 1979.

A new $3.5 billion Financial Assistance for Elementary and Secondary Education Act State block grant consolidates 27 elementary and secondary, vocational, adult, handicapped and library programs.

Existing social services legislation, title XX of the Social Security Act, would be modified by the proposed——

Senator MAGNUSON. Well, wait a minute. Block grants require legislation. You're back on legislation, not money.

Secretary MATHEWS. Well, I was going to describe that money.

Senator MAGNUSON. Well, you haven't got the money and you haven't got the legislation.

Secretary MATHEWS. As I say, I can leave that section out.

Senator MAGNUSON. Well, I think you ought to make the speech to the Legislative Committee.

Secretary MATHEWS. All right, sir.

Senator MAGNUSON. Now, some of this I will personally agree with as a Senator, but not as Chairman of the Labor-HEW Subcommittee on Appropriations. It has nothing to do with us.

Secretary MATHEWS. Well, the reason I thought you might want to be concerned with it is that when we asked you this year to make appropriations, we will ask you to make appropriations within the block grant area along the traditional lines. As I understand it, you had problems of transition in the past, and you've made recommendations.

and we are accommodating. In other words, we are not asking you to wait to appropriate the funds until the legislation has been determined. This is a change from past practice, and I think it really results from suggestions made here in this committee. We hoped that that would please you.

Senator MAGNUSON. Are you so naive that you think we'd appropriate money before we have legislative authority to do it?

Secretary MATHEWS. No, sir. I don't believe that's what we're asking for.

Senator MAGNUSON. Well, do you think you're going to have us do that?

Secretary MATHEWS. No, sir. We're simply saying that we are prepared to make recommendations line by line this time in the traditional form, even though we will come later and make proposals for blocking this together.

Senator MAGNUSON. If you get the legislation.

Secretary MATHEWS. Yes, sir, but prior to getting that legislation, we will make line by line recommendations in the traditional——

Senator MAGNUSON. For money?

Secretary MATHEWS. Yes, sir.

Senator MAGNUSON. With no authority?

Secretary MATHEWS. The traditional authority.

Mr. MILLER. The authority exists.

Secretary MATHEWS. The authority exists, Mr. Chairman, and we'll ask for it like we always have.

Senator MAGNUSON. Well, if you keep it under existing legislation, you're all right.

Secretary MATHEWS. This is existing legislation.

HEALTH BUDGET

In the health field, our request for funding for health services programs, most of which would be folded into the block grant, at a later time, is generally at the same level as the President's original fiscal year 1976 budget request. Examples of the programs for which this is true include community health centers, family planning, migrant health, and emergency medical services. A slight decrease is shown for maternal and child health services, because of the need to obligate more funds in 1976 than we originally intended in order to cover continuation costs, and we are again recommending that no funds be appropriated for comprehensive health grants to States, the so-called 314(d) grants.

Two programs offer major exceptions to a status quo budget for health services.

Here are two programs where we are asking major increases. First of all, for the National Health Service Corps. I take it that you had some personal interest in this. The President's 1977 request for the National Health Service Corps will place 676 health professionals in 330 underserved health care areas.

This is an increase of 14 percent in the number of health professionals and 22 percent in the number of sites staffed in 1976.

Approximately 820,000 people, 22 percent over 1976, will have health care available through this program.

Senator MAGNUSON. If we have this increase in the professionals?

Secretary MATHEWS. That's right, sir.

By 1977, 150 communities which have received Federal support in the past will be self-sufficient and will continue projects started under the National Health Service Corps without additional Federal assistance: $3.9 million will be returned to the Federal Treasury in 1977 as a result of fees collected from patients provided care at National Health Service Corps sites.

Senator MAGNUSON. That is your best estimate.

Secretary MATHEWS. Yes; that is.

Senator MAGNUSON. I hope that turns out to be true.

Secretary MATHEWS. Right.

Senator MAGNUSON. That was the purpose of the bill anyway.

Secretary MATHEWS. Right, sir.

Senator MAGNUSON. So I hope it is going to work out that way.

PUBLIC HEALTH SERVICE HOSPITALS

Secretary MATHEWS. The other area in which there has been a major change would be for the Public Health Service hospitals. I have been well informed of your personal concern for the continuation and upgrading of the Department's Public Health Service hospital system. I understand that concern, but as I look at the health care system in this country, it is impossible for me to defend continued operation of our small network of Federal hospitals to provide medical services to a very limited clientele.

The President's 1977 budget proposes to serve the hospital's primary beneficiaries through the free standing PHS clinics and by contracting with medical facilities in their communities. We will transmit to the Congress legislation necessary to transfer to community use or to close the eight existing PHS hospitals.

Senator MAGNUSON. We are going to have a great disagreement over this.

Secretary MATHEWS. I understand.

Senator MAGNUSON. About their use. This has been going on a long time.

Secretary MATHEWS. Yes, sir.

Senator MAGNUSON. And of course, I'm personally familiar with the one that we have in Seattle and the amount of people it serves, and the Department has always arrived at the conclusion that the need ceased to exist, and we keep coming up with the fact that they're being used more than ever.

Secretary MATHEWS. Yes, sir.

Senator MAGNUSON. And they ought to stay there. And the amount involved is how much?

Mr. YOUNG. $108 million for the eight hospitals.

Senator MAGNUSON. For the eight.

Mr. YOUNG. Yes; roughly $100 million.

Secretary MATHEWS. It is $106,970,000 according to the budget.

Senator MAGNUSON. We had $115 million for the revised figure, and we had $117 million last year. So it's in that figure.

Mr. YOUNG. It's in the neighborhood of $100 million. There was some construction there in prior years, but roughly $100 million.

Senator MAGNUSON. Well, there has to be some maintenance.

Secretary MATHEWS. We have some figures in which you might be interested, concerning the use of these facilities, as follows. According to our statistics, only 69 percent of the hospitals' total capacity will be used in fiscal 1976. Even if the hospitals were scheduled to remain open in 1977, only 53 percent of the total number of persons being served by the hospitals in fiscal 1976 will be primary beneficiaries. The hospitals are located in major metropolitan areas where adequate community facilities are available to care for current Public Health Service hospital beneficiaries.

At least five hospitals are in areas with an excess of hospital beds for community needs. Continued operations——

Senator MAGNUSON. Well, now, the community needs a hospital in Seattle. They want to keep it going. They don't want to take it over.

Secretary MATHEWS. Right, sir.

Senator MAGNUSON. There might be some places where they say so, but we'll have to go into that.

This committee has many, many times just turned this down and put it in the bill and made it mandatory. I see no reason why that will change.

Secretary MATHEWS. For the hospitals to remain operational, substantial capital investment will have to be made to enable them to meet modern community standards.

Senator MAGNUSON. Sure, to keep a hospital you've got to do that. That's part of the cost.

Secretary MATHEWS. Preventive health.

The venereal disease, immunization, rat control, and lead-based paint programs would be funded in the block grant. We are asking your committee to appropriate the same amounts——

Senator MAGNUSON. Their figures in Seattle, when they farmed them out, cost them more than running them, per patient, in the hospital.

Mr. YOUNG. That's generally true in the first year or 2, but over time, I think, in Detroit and other places where these have been closed, that turns out not to be true.

Senator MAGNUSON. Well, some of them ultimately will, but if they're useful, they shouldn't be. But how much have you got in this budget for that? None?

Mr. YOUNG. We have the money in the budget to sustain these hospitals in accordance with the law that was passed under the appropriations rider to a defense construction bill. They have to be maintained by law at their present level, including the staffing. This budget will do that. We have to come back to the Congress, sir, to do anything in terms of transferring or closing these hospitals.

Senator MAGNUSON. But you do have money in the budget to keep them at their present level, is that right.

Mr. YOUNG. Yes, sir, including the staffing.

Senator MAGNUSON. It has to be.

Mr. YOUNG. That's written into the law.

Senator MAGNUSON. All right.

Secretary MATHEWS. That was a point we made earlier, Senator, about particular legislation.

Senator MAGNUSON. We'll get that later.

PREVENTIVE HEALTH

Secretary MATHEWS. Turning to preventive health, the venereal disease, immunization, rat control, and lead-based paint programs would be funded in the block grant. We're asking for your committee to appropriate the same amounts for them as were requested in the 1975 budget of the President.

Two major programs considered by this committee would not be placed in the block grant. We are requesting increases for both of these.

First of all, in occupational health we are requesting a $5 million increase over the original fiscal year 1976 budget. This will permit the National Institute for Occupational Safety and Health, NIOSH, to recommend to the Department of Labor during the next 2 years, criteria on 24 hazardous substances that impinge on the health of 1.7 million workers in the workplace. This compares with 18 criteria on which research was begun in 1976.

Senator MAGNUSON. And this has nothing to do with the number of inspectors or things of that kind.

Secretary MATHEWS. That's correct, Mr. Chairman.

Senator MAGNUSON. That comes under the labor.

Mr. YOUNG. That is the enforcement of these standards, Mr. Chairman.

Senator MAGNUSON. And the $5 million increase will be mainly research?

Secretary MATHEWS. Yes, sir, we are planning to increase significantly the number of hazardous substances that we will take under consideration.

Senator MAGNUSON. OSHA comes under Labor and NIOSH comes under HEW.

Secretary MATHEWS. We in effect have the research arm of that program.

Senator MAGNUSON. Well, it's to find out and report to the enforcement people, surely some things that might be wrong or there might be some things they can do. Again, and this is a lot of preventive health.

Secretary MATHEWS. Extraordinarily useful.

Senator MAGNUSON. In high-risk industries.

Secretary MATHEWS. Yes, sir.

Senator MAGNUSON. I guess we are having a local problem on that. I read several articles in the newspaper about a plant that has created health problems because nobody inspected it.

And apparently nobody did anything about it.

Secretary MATHEWS. I read those same reports.

Senator MAGNUSON. Well, you read it. It's in the paper every day.

Secretary MATHEWS. But you're right. This program does get at the problem.

Senator MAGNUSON. But this is the same idea.

Secretary MATHEWS. Yes, sir, it is.

The budget will also allow intensified efforts to identify and prevent cancer of occupational origin through field studies and epidemiologic investigations in 46 high-risk industries, as compared with 37 in 1976.

LABORATORY IMPROVEMENT

We will provide a $5 million—50 percent over fiscal year 1976—for the laboratory improvement program in the National Center for Disease Control.

Senator MAGNUSON. Is that NIH?

Secretary MATHEWS. No, sir, this is not NIH. It's CDC.

Senator MAGNUSON. Well, at the National Center for Disease Control. Isn't that NIH?

Secretary MATHEWS. No, sir, that's in Atlanta.

Senator MAGNUSON. Oh, that's the one in Atlanta.

Secretary MATHEWS. Known primarily for its work with communicable diseases.

Senator MAGNUSON. Infectious diseases and things of that sort.

Secretary MATHEWS. Right. Smallpox has been a principal focus.

This would permit us to increase the number of laboratories participating in proficiency testing programs from 1,700 to 3,200, thereby increasing the reliability of diagnostic tests performed in the Nation's clinical laboratories. This will result in a saving of both dollars and unnecessary hospitalization.

BIOMEDICAL RESEARCH

We are requesting more than $2.1 billion for biomedical research—$185 million over the President's revised fiscal year 1976 budget. We are holding the Cancer Institute at the current level and requesting $40 million over the revised budget for the Heart Institute. Most significantly, however, we are requesting $110 million more then the 1976 amount in the revised budget for the other research institutes. These latter funds are directed toward redressing the imbalance of resources among institutes.

Senator MAGNUSON. Well, now, this chapter's obsolete after overriding the veto.

Secretary MATHEWS. This was prepared some time ago.

Mr. YOUNG. It was prepared last Friday, Mr. Chairman.

Senator MAGNUSON. Well, it's obsolete.

Mr. MILLER. This makes a comparison to the budget the President submitted to you.

Senator MAGNUSON. Unless you're dealing with the budget you submitted to us, not the one——

Senator SCHWEIKER. When you say you're holding the Cancer Institute to the current level, are you talking about the current level of spending, the current level of your budget, or the current level of what we just passed in the vetoed appropriation?

Secretary MATHEWS. The base figure we are using here is the revised 1976 budget. Any time I use a comparative figure it compares back to the revised 1976 budget, not the appropriated level.

Senator SCHWEIKER. Operating level or budget level?

Secretary MATHEWS. The President's budget.

Mr. YOUNG. Therefore, it would not account for the action of the House and the Senate in the override. It would not account for them.

Senator BROOKE. Would you then say that they are keeping at the level that we have appropriated as a result of the override?

Secretary MATHEWS. No; it doesn't. The figure that we are requesting is not comparable to the figure that is contained in the override.

Mr. YOUNG. Right.

Secretary MATHEWS. Special emphasis would be devoted to emerging research areas such as immunology, aging, and environmental health.

A major thrust of the President's request for NIH is the funding of the initial construction phase of a new ambulatory care facility, and the modernization of the outmoded clinical center. The center's outpatient program will expand from approximately 35,000 visits in 1975 to 195,000 by 1980.

Senator MAGNUSON. All right, now before we do leave this, the staff, because this just happened yesterday, the staff tells me that the revised level that you are talking about is $60 million below the congressional level. Is that correct?

Secretary MATHEWS. That is correct.

Senator MAGNUSON. So it isn't standing still at $60 million below in cancer.

Secretary MATHEWS. For the Cancer Institute that's correct, sir.

Senator MAGNUSON. Is that true in the other institutes?

Secretary MATHEWS. No, sir. The figures I'm looking at now for the 1976 appropriation level show increases for some of the institutes.

CANCER RESEARCH FUNDING

Senator MAGNUSON. Well, why did you pick on cancer?

Secretary MATHEWS. The feeling was that the cancer program we very badly needed to expand the base of research generally because cancer research or any targeted research depends heavily on research competence in other areas.

For example, and these are from my past experience, not my notes, we had a cancer research program and one of the problems we had with the targeted research, quite frankly, was that it did not focus and give enough strength to related areas.

Clinical pharmacology, for example, is essential to cancer research because you have to test the drugs.

Senator MAGNUSON. Well, why don't you do both?

Secretary MATHEWS. Well, we felt it was important with the limited dollars we have——

Senator MAGNUSON. I don't understand why you don't do both.

Secretary MATHEWS. We had a certain limited number of resources.

Senator MAGNUSON. Who wrote this part of the speech for you?

Secretary MATHEWS. The part I just gave I wrote myself.

Senator MAGNUSON. Because you're not a particular expert out at NIH. Who did this? That's the same speech I heard up on the floor that the Senator from California was reading when we voted down the cut in cancer. Exactly the same speech. And I found out some of the doctors, all the way from our friend Dr. Shannon up, who was opposed to a cancer program in the early days and some of the doctors from the University of California that he quoted, were mad because they didn't get a grant.

Secretary MATHEWS. Yes. The information about the need for broader-based research——

Senator MAGNUSON. Well, I don't know why you can't do both.

Secretary MATHEWS [continuing.] Is, I think, sound. It would be ideal to do both, but with the resources we had, we thought it was best to place them here.

Senator SCHWEIKER. Well, as I read these figures here on cancer, Mr. Secretary, you are cutting the level that we just passed in the House and the Senate $157 million in the Cancer Institute. The net effect of what you're saying or you're proposal is that to cut what we just approved this week $157 million, as I read it.

Secretary MATHEWS. I don't have your recent budget with me.

Senator SCHWEIKER. We approved the level of $744 million. Your proposal in the vetoed bill that was overridden, your proposal is $687 million.

Secretary MATHEWS. That's correct, Senator.

Senator SCHWEIKER. Which means it's a cutback of what we just put into law of $157 million in cancer. I'm sorry, it's $57 million.

Secretary MATHEWS. $57 million is correct.

Senator MAGNUSON. I used the figure $60 million, but it's actually $57 million.

Secretary MATHEWS. $57 million is the difference.

Senator BROOKE. Mr. Chairman.

Senator MAGNUSON. Go ahead, go ahead. Go ahead before this gets more confused.

Senator BROOKE. I don't think it's confused. I don't think this subject is confused. I think it was purposefully done. You know we had this battle on the floor and then I chaired the hearings on NIH.

As I understand NIH, they did want to bring about more balance, as the Secretary said, but I specifically asked them whether they wanted to take money out of cancer for these programs.

I don't think that they wanted to. At least they didn't testify that they wanted to take it from cancer.

Secretary MATHEWS. I think you understood their position correctly.

Senator BROOKE. Well, I hope I understand their position correctly. It would appear to me that this budget would be taking it from cancer in order to give it to these other institutes.

Secretary MATHEWS. I wouldn't dispute the fact. As I have already said, our proposal is to hold the cancer budget level and to increase the others.

Senator BROOKE. So then actually you are taking from cancer.

Secretary MATHEWS. I'm not quite sure that that is quite accurate. We are holding cancer level, which is at a level below what the recently passed bill calls for.

Senator BROOKE. But it appears that there's a 4-percent increase in deaths by cancer, and are you saying that you believe we are at the highest level that we should be insofar as cancer's concerned?

Secretary MATHEWS. Not at all, not at all. But the figures on cancer death have risen and during this same period we were making marked increases in that research. We were targeting that research. I think we need to rethink our policy on targeting research funds. I think the

critical need in cancer research is for a much more broadly based effort than we have had.

Senator BROOKE. Now that we have taken the action in both the House and the Senate, and that's the law, what would your revised figures be?

Secretary MATHEWS. We don't have those.

Senator BROOKE. Would it change your figures at all?

Secretary MATHEWS. Not in all honesty, Senator.

Mr. YOUNG. Senator, we do not have any new figures at all. We have no new numbers in terms of the action that the Senate took yesterday.

Senator BROOKE. Well, it certainly appears to be a $56 million decrease, 1976 to 1977.

Secretary MATHEWS. That's correct.

Senator BROOKE. And that's what you are proposing.

Secretary MATHEWS. That's what we are proposing.

Senator BROOKE. And you testified to some budget constraints?

Secretary MATHEWS. We do, sir.

Mr. YOUNG. We also justified on the basis of the growth in the funds committed to cancer, which if I remember the statistics are not as large a killer as heart disease. The cancer budget has grown roughly from about $200 million in 1970 in the last 4 or 5 years to about $688 million. That's about a 200 percent increase.

Senator MAGNUSON. What's wrong with that?

Mr. YOUNG. We think what is wrong with that is that there may be other priorities equal or greater.

Senator CHILES. Who sets those priorities?

Mr. YOUNG. Priorities are set in the pluralistic political system which the President proposes and you gentlemen often do not agree.

Senator SCHWEIKER. But even if you take that argument, this latest vetoed bill had a level of $349 million for heart, now, which you say is a greater killer. Yet you're cutting it down to $342 million.

So even following that argument, you're cutting the heart program by $7 million, the leading killer. So I don't follow.

Mr. YOUNG. Over the action of the House and Senate that is true.

Senator SCHWEIKER. Well, that's the leading killer, but you're showing a $7 million cut in view of a 7 percent inflation.

So in terms of constant dollars, it's really almost a 10 percent cut.

Senator BROOKE. When you say "over the House and Senate action," isn't that what we're dealing with now?

Secretary MATHEWS. When the President prepared his budget we submitted this, we were trying to display his policy positions and they proceed from an assumption that a budget of $394.2 is the correct figure for the Federal budget. Then the question became how do you allocate those $394.2 billion? What kind of policy position would you take?

I have described the policy position here and the way those numbers falling out from that initial assumption, so I think you can understand the President's position only by understanding that first of all he determined that the figure that he wanted to recommend was $395 billion, and this figure relates to that.

Senator BROOKE. $394.2 billion. I can understand that. But when you say how much you are increasing or decreasing it by, that really is not accurate because that is based on the President's fiscal year 1976 budget. That's not based on the existing law and the existing law as of yesterday, is a different figure than you've used here in your statement.

Is that correct?

Mr. YOUNG. That is correct.

Senator BROOKE. So when you say it doesn't change it, you mean so far as your budget is concerned it doesn't change the figures you're proposing.

Secretary MATHEWS. That's correct.

Senator BROOKE. Then we would have to change the amount of the decrease or the amount of the increase.

Mr. YOUNG. That's correct, Senator, correct.

Mr. MILLER. Further Senator Brooke, is the materials that we provide Congress at their request, which are essentially their documents, which are called justifications, we show the change that you are talking about.

Senator BROOKE. All right.

Secretary MATHEWS. But as I say, this material was prepared sometime——

Senator MAGNUSON. You're familiar with the fact that, let's take cancer, 535 Members of Congress have voted for the increases every year.

Secretary MATHEWS. Yes.

Senator MAGNUSON. But you're not concerned with what the legislative body does?

Secretary MATHEWS. I wouldn't say that.

Senator MAGNUSON. 535 have voted every year for the increase.

Secretary MATHEWS. I'm quite aware of that.

Senator SCHWEIKER. Well, part of the real problem, which we haven't mentioned is, you hold the biomedical research budget almost constant from what we just voted for, $2.1 billion, versus your 1977 request for $2.1 billion.

So it's virtually constant. Yet the defense budget goes up $9 billion. So we increase defense $9 billion and we hold biomedical research constant, which means they take at least a 7-percent cut because of inflation.

Now that shows what priorities are. That's what the issue is and that's what shows what the priorities are.

Senator MAGNUSON. Yes, what are the issues and what are the priorities.

Secretary MATHEWS. Well, as we pointed out earlier, when you look at our budget in the allocations that the President made, our increase is larger in his allocation than the increase he gave to the Defense Department.

Mr. MILLER. May I say one other thing, Senator Schweiker?

Senator SCHWEIKER. Not on NIH.

Secretary MATHEWS. In total budget, our percentage of the total Federal budget went up in the President's recommendation in 1977.

Senator SCHWEIKER. Because you're putting social security in there.

Secretary MATHEWS. Yes.

Senator SCHWEIKER. Well, we're playing games there.

Secretary MATHEWS. All the increases were not in social security.

Senator SCHWEIKER. Well, they certainly weren't in biomedical research or NIH.

Mr. MILLER. Senator Schweiker, most of the increases in Defense Department are to cover high continuation costs. The NIH budget that we are proposing will cover all the continuation costs at NIH. It's a question of how much new work is started, and I would doubt the Defense Department is able to start more new projects than NIH.

Senator SCHWEIKER. Well, that's sort of comparing apples and oranges. You've got tanks on the production line. That's one thing. You've biomedical research projects. You are certainly not going to be funding the same number of medical research projects and you're certainly not going to by funding the same kind of research with a 7 percent drop in dollars that you were before unless you're a magician. How can you get the same dollar buy for research at 7 percent less money?

Mr. MILLER. But we could cover continuation costs of NIH projects that were started, but that's about all.

Senator SCHWEIKER. But then you make up for the gap by not launching new projects, so your new project level has dropped.

Mr. MILLER. That's correct.

Senator MAGNUSON. And the HEW, it is only up here and there because of noncontrollables.

Mr. MILLER. Well, essentially——

Senator MAGNUSON. Well, is that correct or not? Something that you have nothing to do with, that Congress requires to do. So you say, "Oh, we're doing great, a great job in this field." And it is noncontrollables that cause increases—if you do have any showing, as the Senator from Pennsylvania says, there's no showing at all.

Senator BROOKE. How much consideration did you give to your professionals on these proposals?

Secretary MATHEWS. Salary increases or staff-level increases?

Mr. YOUNG. I think the Senator is asking professionals.

Secretary MATHEWS. I think it's fair to say that in developing this particular budget, the President looked at what he felt were larger national issues, that is, he looked at the condition of the relationship in the Federal Government today, he looked at general, social, political, and economic concerns, and I think the President would say quite unapologetically, that it was these considerations, rather than functional, specialized, or professional considerations that drove this particular budget.

There is an unabashed statement in the budget and the block grants in the general direction now that the President wishes to go in a different direction.

Senator MAGNUSON. Block grants are not going to save any money?

Secretary MATHEWS. No, sir, they're not proposed to, they're not proposed to.

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Senator MAGNUSON. As a matter of fact, they're going to get less money if you have a block grant.

Secretary MATHEWS. We are proposing some more money in the blocks.

Senator MAGNUSON. Oh, they're going to get less money. The Governors, they were taken for a nice ride down here. It's going to be great. They're going to have less money now. I'll give you chapter and verse on that.

Secretary MATHEWS. Well, we have a different kind of relationship with the States.

THE ALCOHOLISM, DRUG ABUSE, AND MENTAL HEALTH ADMINISTRATION

Senator MAGNUSON. Well, let me ask one question here because I just had Mr. Dirks add this up. He says the total 1977 controllable health budget is down $721 million from the 1976 bill enacted yesterday. Is that a correct figure?

Mr. YOUNG. I think that's a pretty good number.

Senator MAGNUSON. Is that a good figure?

Mr. YOUNG. That's approximate.

Secretary MATHEWS. Well, Mr. Miller says somewhat smaller than that.

Mr. YOUNG. Harley, for one time you underestimate this. It's a little higher than that.

Senator MAGNUSON. $721 million is low. Well, that's nice. But you are down $721 million plus whatever the figure is from the bill that the Congress enacted yesterday.

Secretary MATHEWS. That is correct, sir.

Senator MAGNUSON. All right. In the controllable items.

Secretary MATHEWS. In health. I believe that's the health field.

Senator MAGNUSON. So that's going backward, isn't it, quite a bit.

Secretary MATHEWS. Well, as I say, that proceeds from the President's assumption as to the proper 1977 level.

Senator MAGNUSON. Well, why do you zero in on these? Noncontrollables have nothing to do with what we're talking about.

Secretary MATHEWS. I'm talking about the total budget. The President does have a different position on what the total budget should be as to the Congress.

Senator MAGNUSON. He has different priorities than we have.

Secretary MATHEWS. Also a different position on the total.

Senator MAGNUSON. Well, we're going to have a congressional budget of the same figure.

Secretary MATHEWS. $394 million?

Senator MAGNUSON. Yes, right in there, give or take 2 or 3 percent.

Mr. YOUNG. Mr. Chairman, I appreciate the views of the chairman and this Appropriations Committee, but if you look at the $394 million or the $410 million, if you like it better, you have to give increases for the noncontrollables such as medicare, which does serve people. And you've got about $4 billion that goes into those kinds of things. You people in the Congress have agreed to take a look at the overview. So does the President. Therefore, we're always going to be in disagreement with the group here that looks at part of it, roughly $44 billion. There's no way to end that argument, sir.

Senator BROOKE. Were you given a figure by the administration and told to work within that figure?

Mr. YOUNG. Yes, sir.

Senator BROOKE. Or did you come up with a budget of your own and negotiate and pare it down? I'd just like to understand that process.

Mr. YOUNG. Let me describe the process. We started in the spring with sort of an idea of where the economy's going to go. Economists disagree. You certainly know that. On that basis the President sets an overall number for the Federal budget. The agencies are given ceilings. OK? They used to be targets. They're called ceilings. We work within those to you see how many of these things talking with Ted Cooper, Ted Bell, other people, how much can you get in, thinking about the administration's priorities, thinking about what the Congress is going to do, thinking about how you voted last year.

Senator BROOKE. And thinking about your own priorities.

Mr. YOUNG. And the President's priorities. You know, the President, sometimes you want to do know about the Secretary's.

Senator BROOKE. The Secretary ought to have some input into that.

Mr. YOUNG. He does, and I'll explain that in a minute. Then you adjust that during the appeal process during the fall. The HEW numbers went up significantly.

Senator BROOKE. Above the ceiling that was set?

Mr. YOUNG. But they primarily went up in medicaid, social security, and the others because those are the groups that are aged, are without income, and require the most services, and those are how the priorities are set downtown. And you people have different priorities and different views, and that is the debate, and that's how the process works.

Senator MAGNUSON. Well, we know how it works. Are you considering rescissions and deferrals in these figures you're bringing up here?

Mr. MILLER. The recissions that are for the first supplemental appropriation are the 1976 column.

Senator MAGNUSON How many rescissions do you have coming up?

Mr. MILLER. Well, we have figures before you now.

Senator MAGNUSON. And we've turned them all down.

Mr. MILLER. You haven't considered them.

Senator BROOKE. We haven't had the new rescissions.

Mr. MILLER. No, no. You have before you the rescissions for the education bill and the rescissions for the first supplemental. No action on rescissions has been taken with respect to the bill which you overrode yesterday—the veto which you overrode yesterday.

Senator MAGNUSON. There's a constant flow of rescissions up here, even after we act. And we rejected, as far as I know, every one because it ignores the intent of Congress. This is one of the reasons and we are part of this government too, at least I thought we were.

Secretary MATHEWS. Well, I'm willing to admit that, sir.

Senator SCHWEIKER. You're one of the few people.

Senator MAGNUSON. You're one of the few people that have admitted it.

Secretary MATHEWS. The Alcoholism, Drug Abuse, and Mental Health Administration, if I could describe the recommendations we're making there.

With respect to the drug abuse program, the 1977 budget includes an increase of $25.4 million over the revised estimate for 1976 to implement the recommendation of the white paper on drug abuse.

This particular recommendation would provide as follows: 7,000 additional treatment slots will be established in communities, bringing to 102,000 the number of slots supported by the Federal budget.

Senator MAGNUSON. What do you mean by slots?

Secretary MATHEWS. Those are patient treatment places as opposed to staff places. In a hospital sense; it would be individuals who can receive treatment.

New demonstration projects for the treatment of amphetamine and barbiturate abuses will be undertaken.

A major patient followup will be initiated to assess the long-term effectiveness of drug abuse treatment.

HEALTH PROFESSIONS EDUCATION

On the Health Professions Education, with the exception of nursing support, the programs contained under this heading——

Senator MAGNUSON. Now how much money is contained in your program here on drug abuse and mental health? How much more are you asking in this budget than we had last year, if any?

Secretary MATHEWS. The figures compare as follows for all of the issues that you are interested in.

The President's budget recommends $623,331,000. That compares with a revised budget recommendation of $644 million, which compares with your appropriation level of $624 million.

So roughly it is the same. $624 million as compared to $623 million.

Senator MAGNUSON. Well, you are $173 million below the 1976 enacted level. How can you say you're increasing it?

Secretary MATHEWS. No, sir, I say they are roughly the same.

Senator MAGNUSON. You're $173 million below.

Mr. MILLER. We're only talking about drug abuse.

Senator MAGNUSON. I'm talking about Alcohol, Drug Abuse and Mental Health. You're $173 million below.

Secretary MATHEWS. The figure I gave you is simply the figure, the total figure.

Senator MAGNUSON. I'm looking at the overall program.

Secretary MATHEWS. Charley, do you have the total figure?

Senator MAGNUSON. $173 million below. That's our figure.

Mr. MILLER. We'll straighten the figures out.

Senator MAGNUSON. But you're below. You are below, Why all these speeches saying that you are increasing funding requests?

Mr. MILLER. We only related that to drug abuse.

Secretary MATHEWS. In all these figures where we say we're making a comparison, we're comparing them with the 1976 budget.

Senator MAGNUSON. Well, somebody would agree that you should be below $173 million, but don't make speeches, or don't have testimony that you're going to be above. You are below the 1976.

Secretary MATHEWS. Enacted.

Senator MAGNUSON. Yes.

Secretary MATHEWS. Right.

Senator BROOKE. Mr. Secretary, if you could yield just a minute, I want to be sure, under your revised estimate here, do these reflect anticipated rescissions?

Mr. YOUNG. Yes.

Senator BROOKE. Do you anticipate that we would act favorably on your recommendations for rescissions?

Secretary MATHEWS. Yes.

Senator BROOKE. All right.

Secretary MATHEWS. With the exception of nursing support, the programs contained under this heading remain, after 2 years, unauthorized in substantive legislation and funded under the continuing resolution. New legislation must, therefore, be passed before your committee can appropriate funds. Consequently, our budget is based on our legislative proposals. These proposals focus on redressing the imbalances in the specialty and geographic distribution of health professionals. This is a shift from prior emphasis on increasing the supply of health care providers by expanding enrollments. That goal has been met as evidenced by the increase in medical school enrollments of 57 percent between 1969 and 1975.

TOTAL AMOUNT REQUESTED IN 1977

Approximately 80,000 students will be supported by a $120 million school program for capitation assistance to schools of medicine, osteopathy, and dentistry.

Senator SCHWEIKER. Mr. Secretary, what level of capitation is that? In other words, you're projecting a certain level. How much capitation are you giving us?

Secretary MATHEWS. Per individual institution, you mean?

Senator SCHWEIKER. Right.

Secretary MATHEWS. I don't have that figure.

Mr. MILLER. It's based on an entirely different legislative proposal. It does not attempt to give a figure for every student in the school, but only for those that meet the new criteria.

Senator SCHWEIKER. Well, the administration package is either $1,500 per capitation or $2,100. You had to arrive at the figure somehow.

Mr. MILLER. We don't have the figure with us. We'll have to provide it.

Senator SCHWEIKER. Well, how can you say you recommended $120 million, if you don't know what capitation level you're recommending?

We've been fighting with this for 4 years now in our health committee, and I'd like to know where you're coming down or we're going to have to fight another 4. But how much the individual capitation is will determine whether $120 million is enough.

Mr. KURZMAN. We'd be happy to supply that, Senator Schweiker.

Senator SCHWEIKER. You don't have that?

Secretary MATHEWS. It's in the legislative proposal, but not in this one.

Senator SCHWEIKER. Which legislative proposal? The one immediately before the Senate in the compromise bill, or the one that came out of the House or the original package?

Mr. KURZMAN. The administration package.

Senator SCHWEIKER. The latest compromise, the newest compromise?

Mr. KURZMAN. The newest administration proposal.

Senator SCHWEIKER. And that reflects that total spending level, you think.

Senator MAGNUSON. We'd better have it in the record to find out how much per student you're talking about. This is what they're concerned about.

Secretary MATHEWS. We'll be glad to put that in Senator.

Mr. MILLER. We have that information, it's around $1,500.

Senator MAGNUSON. I was thinking it was around that.

Secretary MATHEWS. Here are the stipulations that we are proposing:

That the schools will set aside 20 percent of their 1978 and 1979 entering class for applicants who will practice in underserved areas;

Establish an identifiable training program——

Senator MAGNUSON. Let's get this straight. Will this be a requirement to make them eligible for a Federal grant, a school? In other words, it would be a Federal requirement.

Secretary MATHEWS. Yes, sir.

Senator MAGNUSON. Now aren't you legislating there?

Secretary MATHEWS. That would go through legislation. These would be the conditions.

Senator MAGNUSON. I don't say that this is not a good idea, but I think you're legislating.

Mr. MILLER. You and we have to live under the continuing resolution, Mr. Chairman, until there is legislation. There is no authority for these programs. So you and we both have to live under the continuing resolution until there is legislation.

Senator SCHWEIKER. But you confused me because you just said a moment ago 80,000 students will be supported by $120 million programed for capitation. Now that is the capitation grant we're operating now? Is that the one in the compromise package that you put before the health committee in the past?

Mr. YOUNG. That is the administration proposal. The $120 million will take care of 80,000 students at the $1,500 capitation.

Senator SCHWEIKER. At the new proposal.

Mr. YOUNG. That's the administration's November proposal.

Senator MAGNUSON. There's nothing that we can do about it until the legislation comes.

Mr. YOUNG. Correct.

Senator SCHWEIKER. Except we are supporting capitation grants now not too far from that level.

Mr. YOUNG. Correct.

Senator BROOKE. I have to leave shortly. I've got to ask a question that still concerns me about the fact that your budget assumes that we will accept your proposals on rescission and deferrals.

Secretary MATHEWS. Right.

Senator BROOKE. Now historically we have not accepted most of your rescissions and the deferrals have been rejected. So when you include that, it seems to me to be sheer public relations because it makes your budget look better.

I'm just wondering, is that a sound practice for the Department to use?

Secretary MATHEWS. Well, it's uniform, I think, throughout all the budgets and the reason is that the Congress has not acted on those——

Senator MAGNUSON. I suggest you don't follow all budget procedures. Have your own.

Secretary MATHEWS. I suspect you'll find that all of the executive budgets will have a policy similarity in that regard and the reason——

Senator BROOKE. That wouldn't make it right, though. I mean is it a sound practice? It looks like it is something which it isn't and that disturbes me.

Secretary MATHEWS. I think there is a reasonable defense in that the Congress has not, in fact, acted on those proposals and therefore it's legitimate to report what the factual situation is when you're making comparisons, and there's no effort to hide that fact. We're quite clear.

Senator BROOKE. You think this is clearly understood?

Secretary MATHEWS. Well, certainly I would make it clear in any questions you asked me. There is a reason for it. One might say, well, you know, if one compares any of these figures with any others, there are better or poorer comparisons depending on what figures you select. I think as long as you're candid about what figures you use, that makes for reasonable debate.

Approximately 4,600 students who agree to serve in the Public Health Service, in other Federal health service, or in a health manpower shortage area will be supported by a $35 million health service scholarship program; $128 million will support special projects, including: Family medicine and primary care residency programs; physician extenders and dental assistants projects; programs to expand the enrollment of disadvantaged students; and nearly 560——

Senator MAGNUSON. Now when you talk about disadvantaged students, you're talking about economically disadvantaged students?

Secretary MATHEWS. That's correct.

Senator MAGNUSON. There are a lot of other disadvantages that are not economic.

Secretary MATHEWS. Right.

Senator MAGNUSON. And that's the reason for capitation grants, institutional loans, and all of these programs we've inaugurated, economically, and particularly in the health field, where it costs so much to get educated, and there are a lot of people particularly who just can't afford to go through medical school.

Secretary MATHEWS. Extraordinarily expensive is the point. That's correct.

Senator MAGNUSON. When I was a young man, I thought about going and being a doctor. Well, I took a look down the road and I found that it was just too long and too expensive, so I became a lawyer. I don't know who suffered by that, but that's what happened.

[General laughter.]

HEW RESCISSIONS

Senator BROOKE. You know, I don't want to belabor the point, but the staff just handed me the paper indicating that HEW has 43 percent of all rescissions, and we have yet to accept one.

Secretary MATHEWS. And yet, of course, we have 35 percent of the budget, 35 to 40 percent of the budget.

Senator BROOKE. And it is increasing.

Mr. MILLER. But rescissions are generally directed toward increases over the President's requests, and we had more than 43 percent of those increases.

Senator MAGNUSON. Oh, come on, now. I don't know how we keep this up. I get the same, it's just like a broken record every year on noncontrollables. That's where they jump on. And then they use—not noncontrollable, but controllable amounts to make up, to do what they have to do with noncontrollables, and then say: "Oh, look what the Government is spending on social needs."

Secretary MATHEWS. Yes, sir. Wouldn't it be fair to say——

Senator MAGNUSON. The Government isn't spending a nickle in social security. It's insurance. People are paying in their own money. It's like the highway fund. We collect the gas taxes and turn it back. But anyway, let's not belabor that point.

Senator BROOKE. It seems to me they really are ignoring congressional intent and the Budget Act by constantly coming up here with these rescissions.

Do you think that there's any merit to that?

Mr. YOUNG. Senator, I think the Reform Act may need some perfecting changes.

Senator BROOKE. Well, maybe it does, but it seems to me you may harm the effectiveness of many programs by creating uncertainty and unnecessary delays in allocating funds.

Mr. YOUNG. Well, I don't think there's any question that the current procedures, both in the executive branch and in the Congress, have gotten to the point where if I were a contractor, a grantee, a local education agency, a hospital or a university, I wouldn't know what to do.

Senator BROOKE. Of course you wouldn't know what to do. That's precisely what I'm worried about. Can't we do something about that?

Secretary MATHEWS. I agree that there ought to be a generalized budget reform, but the point Mr. Young makes is well taken; that there probably ought to be a general reform of the way we do budgeting in the Government in general.

Senator MAGNUSON. The executive was created to carry out the intent of the legislature. That was its whole purpose. And we just can't seem to get the intent carried out.

Before you came the name of the game was impoundment. Then we had to pass a bill; we had to go to courts and everything to make them spend money that we said should be spent.

We're not talking about saving money by putting things together. We are talking about when we say so——

Secretary MATHEWS. Yes.

Senator MAGNUSON. Old Charlie sends up your rescissions. We get them every week, you know, and after we say, over and over again, right or wrong this is what we intended.

Senator BROOKE. We feel your presence, Charlie. We know you're there.

Mr. MILLER. I feel yours, too.

Secretary MATHEWS. I think it should be said that this budget proceeds following the laws laid down by Congress for making reports to Congress.

Senator MAGNUSON. You have a right to give us advice about the budget, and this is good. Actually, if you look back, we've never been

too far apart, percentagewise, over the budgets. We used to have some appropriations committees that would cut it considerably. But this field, this bill is very sensitive. It deals with human beings. And I'd rather go overboard a little bit than have it too little. Some of the other budgets, there's no problem with them. But they don't deal with human beings. This deals directly and indirectly with every person in the United States, this budget, every person. I don't care who they are.

Mr. BROOKE. And to circumvent our intent, we get a slew of rescissions and deferrals.

Senator MAGNUSON. And we get all of that in this particular budget.

Now, sure, it's your responsibility to come up here and tell us what you think about these programs and what you think should be done, but when Congress tells you what to do, I don't see how you can ignore it. My God, we had so many impoundments that we had to go to court, and in the health field we had six cases going in court at one time, and every one of them we won.

Secretary MATHEWS. I would just, as I say——

Senator MAGNUSON. Then they loosened up and now they turn around and are coming back with rescissions.

Secretary MATHEWS. But those do follow the procedures laid down under the law, that we are playing exactly by the rules in the rescissions proceedings.

Senator BROOKE. They are lawful.

Secretary MATHEWS. That's right.

Senator MAGNUSON. You've lost 35 cases in a row up to now. Sure you could come up and give us advice, otherwise, what's the use of us having any hearings about anything, listening to 300 or 400 witnesses in all fields? We might as well just listen to you and say thank you very much and don't do any more about it because it isn't going to be carried out.

Senator BROOKE. The people in the field can't plan because year after year we pass a law they say, "My God, we might get a rescission."

Mr. YOUNG. Well, I might say, Mr. Brooke, that Congress may well wish to modify the Budget Reform Act. This answer may cost my job.

Senator MAGNUSON. That might not be a bad idea.

Mr. YOUNG. I'd take my retirement, too.

The rescission thing is a real problem for all parties, and you may want to talk to the President, whoever he may be, to change that part of the law. This was the answer of the Congress to the anti-impoundment efforts by the executive branch which turned out to be wrong, as determined by the Court. This was a substitute. It's obviously causing problems and uncertainty.

Senator BROOKE. People just don't know.

Senator MAGNUSON. The uncertainty complaints we get is that they really don't know in the field of Federal grants and health or education what they are going to get until late in the year.

Secretary MATHEWS. That was one of the reasons we're proposing changes in the legislation. We are coming to you this time with recommendations under existing legislation, and that is a response on our part to that problem.

Senator MAGNUSON. There's just one thing. I don't want to play with this. It's not in this particular area, but the administration keeps

coming up, and never recommends any money for class B students in impacted aid.

Secretary MATHEWS. That's correct.

Senator MAGNUSON. Now, I'm not so sure I don't agree with them, but they are legislating, and they won't go to the legislative committee and change it.

Secretary MATHEWS. I believe we will, sir. I believe we have to ask for legislation.

Senator MAGNUSON. But for the first time you've got a bill up there that they say they are not going to touch. But that's the way to go at it.

Secretary MATHEWS. Again, I believe we have followed——

Senator MAGNUSON. I think you have a bill up there now.

Secretary MATHEWS. Well, we aren't going to change the way we are proceeding.

Senator BROOKE. I accept Jack Young's proposal and his willingness to be the lead-off witness for budget reform.

Mr. MILLER. As a private citizen——

Mr. YOUNG. I may well be after this. [General laughter.]

Senator BROOKE. I think that's the way to go because we're going to have these problems. We don't want to go back to the courts and go through that painful process. But I think we've got to have budget reform because it's not fair to the people.

Senator MAGNUSON. All right now, let's go ahead.

Secretary MATHEWS. All right.

PROFESSIONAL STANDARDS REVIEW ORGANIZATION

The 1977 level will provide for the development of PSRO's in all of the 203 PSRO areas nationwide. Of these, approximately 120 will actually be performing review of hospital admissions in fiscal year 1977.

It is estimated that 3 million admissions of medicare and medicaid patients, or 27 percent of the total, will be reviewed by PSRO's in 1977.

I might say to you I think this is a first rate program. That's my own judgment. There is an increase for this. I am pleased to see it. It will mean that we will be active in all of the areas, will not have them fully in place, but we will be covering a major portion of admissions, based on past experience.

Senator MAGNUSON. And I think this is a program here where we can save some money.

Secretary MATHEWS. I think it is, too, sir. I think not only in terms of money, which we cited $150 million, but I testified earlier this week that this is one of the best answers to the problem that is being discussed now, unnecessary utilization and unnecessary surgery.

In addition to the $62 million provided in this account for PSRO's, an additional $27 million will be obligated from medicare and medicaid moneys to pay for the actual costs of review. This is the result of the recent enactment of amendments to the Social Security Act.

Senator BROOKE. You increase it by $14 million, approximately, is that correct?

Secretary MATHEWS. The figures I have indicate we have gone from $47 million up to $62 million, that's correct. And this is both above

the President's revised—it's above what you passed in 1976 and well above what you passed in 1975. So there are major increases by any standard of comparison.

Senator MAGNUSON. It's a comparatively new program and we had to give them money to get it started.

Senator BROOKE. How many admissions will be reviewed?

Secretary MATHEWS. We ought to be able to cover about 27 percent or about $3 million.

Senator BROOKE. That's an increase of what?

Secretary MATHEWS. That's a fairly significant increase. I don't think we have the figures there on it, but it will mean that we will have a PSRO organization under development in all of the areas.

Now there would likely be in operation on only about 120 of them, but this is a substantial increase over what we had.

Senator MAGNUSON. Now is this what you were talking about when you testified earlier this week, is it?

Secretary MATHEWS. Yes, sir, it is.

Now St. Elizabeths Hospital.

Senator MAGNUSON. Well, you can just skip that. The committee will take a look at that.

Secretary MATHEWS. We are making a recommendation to correct that situation, and we do want you to know that.

Senator MAGNUSON. Well, let's make the record clear. There's been a move to transfer St. Elizabeths this has been going on now, I don't know how long, to the city, to the District. That still hasn't taken place.

Secretary MATHEWS. No, sir. We still advocate that, but since we have the responsibility——

Senator MAGNUSON. We do too, we do too.

Secretary MATHEWS [continuing]. I think we have an obligation to correct the deficiencies.

Senator MAGNUSON. Something should be done.

Secretary MATHEWS. That should be corrected.

ELEMENTARY AND SECONDARY EDUCATION

Most of the elementary and secondary education programs are included in the block grant. The funding requests before you under existing authority generally ask that you appropriate funds for these programs at the revised fiscal year 1976 level.

We are asking for $90 million in fiscal year 1977 for bilingual education, which is not included in the block grant, a $10 million increase above the revised fiscal year 1976 level.

This would provide for support for more than 360 classroom demonstrations in which some 185,000 bilingual children would participate. This would be a program increase of approximately 12 percent.

Senator MAGNUSON. All right, how much in dollars and cents is it over or under 1976?

Mr. MILLER. Do you mean under the appropriated amounts?

Secretary MATHEWS. It's $8 million under. You enacted $98 million. We are recommending $90 million.

Senator MAGNUSON. So you're $8 million under.

Secretary MATHEWS. That's correct, sir.

Senator MAGNUSON. Then how do you arrive that it's going to be an increase of 12 percent?

Secretary MATHEWS. That is comparing it to the 1976 revised level.

As I warned you in the beginning, this entire report is based on the 1976 revised level.

Senator BROOKE. It looks to me like it's $7,770,000 under.

Secretary MATHEWS. We are indeed under the enacted level as of yesterday.

Senator MAGNUSON. The 12 percent is inoperative, huh?

Secretary MATHEWS. Well, it's 12 percent of something that you're not comparing it with.

Senator BROOKE. But if you say decrease instead of increase——

EDUCATION FOR THE HANDICAPPED

Secretary MATHEWS. All of the education for the handicapped programs would be included in the block grant except for deaf-blind centers. Our appropriation request provides an increase of $35 million or 46 percent over the revised fiscal year 1976 budget and would permit us to increase from 300,000 to 425,000 the number of children served under the State grant program.

Senator MAGNUSON. If the States match it.

Secretary MATHEWS. In the block grants the States there are no matching requirements as we are going to propose it in the legislation.

Senator MAGNUSON. On the propose, but there are some matching requirements.

Secretary MATHEWS. That's right.

Secretary MAGNUSON. And the amount wouldn't go up to $425 million unless the States would participate more. Isn't that correct?

Secretary MATHEWS. I don't know from what that is based.

Senator MAGNUSON. As of now.

Mr. MILLER. I don't think there's ever been a problem with State matching for the handicapped program.

Senator MAGNUSON. But they still have to do something.

Secretary MATHEWS. I think the question was whether $425 million figure anticipated a State match. It does.

IMPACT AID

We are still asking the Congress to reform the impact aid program. We recognize the pitfalls, but we feel we must keep this issue before you.

Senator MAGNUSON. All right. Now you don't have to read all of this. It's an old story. You don't have to read it all. We'll put it all in the record, but how can we do anything about it until there is legislation to revise the program?

Secretary MATHEWS. You cannot and as I assure you here we are submitting legislation to the Congress.

Senator MAGNUSON. I understand that and I think Senator Cotton and I one time proposed legislation. We thought some of it was going too far, but we never got any place with it. Maybe you will do better than we did. I don't know.

Secretary MATHEWS. We will surely try.

Senator MAGNUSON. But in the meantime you must admit we've got to deal with class B students somewhere up there.

Secretary Mathews. I would fully admit that we have to change the legislation.

Senator Magnuson. And this is a very popular program with Congress.

Secretary Mathews. Indeed, sir.

Senator Chiles. Mr. Secretary, I hate to interrupt you.

Secretary Mathews. Well, you go right ahead. I'm here at your pleasure.

Senator Chiles. I just wanted to ask you; as indicated in the letter that we delivered to you yesterday from Chairman McClellan, Chairman Magnuson, and myself, this subcommittee's engaged in an effort to obtain a better perspective of the HEW budget by sorting out the expenditures for many programs into a set of major missions and end-purposes. And based on a trial run last year with our subcommittee staff and GAO doing the work to produce such a display, the subcommittee decided to require a formal submission of the relevant information from HEW as part of the 1977 budget justifications. I think our staff has worked with your staff to develop a process to produce a set of categories for the health and education areas. This will make it feasible to provide information which will highlight the concerns that we have while considering this year's budget.

I think it is important to note that we are seeking not just a sorting out of programs but an allocation of funds within the programs and thus, for example, we would want to know for each program how much money is going for research, how much for demonstration projects and innovative methods and how much for support of ongoing services.

Secretary Mathews. Surely.

Senator Chiles. And then I think we also would get a better idea of where our programs complement or duplicate each other and where we have gaps.

We found an education area last year that we had 8 different programs contributing to education for the disadvantaged and 14 for education for the handicapped, 11 for improving educational administration and management, and 30 attempting to upgrade various aspects of the quality of education.

These sort of things I think would be out where we can understand and we can see them and I just wanted to tell you that we certainly would appreciate your cooperation.

Secretary Mathews. Well, I can assure you now that you will have it. They'll be no problem in getting you the information that you need as you want it displayed.

Senator Chiles. Thank you, sir. I understand we've kind of moved up our hearing dates on you, so I know that that is going to be some difficulty on how quick we can work this out.

Secretary Mathews. Particularly with the new format.

Senator Chiles. But we'd like to work this in. If we can't get it all as the hearings first start, maybe we'd like to hold a hearing and recapitulation, and we could come back and get it laid out.

Secretary Mathews. Surely. But we will work on it now.

Senator Chiles. Thank you very much. We will insert the information in the record at this point.

[The information follows:]

United States Senate
COMMITTEE ON APPROPRIATIONS
WASHINGTON, D.C. 20510

January 22, 1976

Dear Mr. Secretary:

Last year, the Appropriations Committee agreed that a revised functional budget display oriented to end-purpose needs would be helpful in its considerations of the 1976 HEW budget.

The committee concluded that there is a need for information to more clearly identify the end-purposes or program objectives that funds are being expended for, so that we might see an overall pattern, not just dozens of scattered appropriations for each program activity. We are seeking a simplified framework, so that we could understand the programs and priorities in the HEW budget.

On October 16, 1974, we wrote Secretary Weinberger to initiate a joint effort with HEW. Later, the General Accounting Office joined with us in defining new functional categories and allocating program costs to their identified end-purposes.

The committee found this first effort promising, although the displays were not completed in time for effective use during our appropriation hearings. However, we were pleased that Secretary Weinberger endorsed this initial effort when he appeared before the subcommittee. Consequently, in our report on the 1976 appropriation (94-366, page 26), we expressed our intention to continue to refine and use this approach. We hope that a clearer presentation of the different objectives of present programs will aid us in discussing the needs and priorities for funding in the coming year.

In this regard, Senator Chiles' staff has been meeting individually with members of your office to gain their insights into the specifications of program objectives which have been used internally within HEW, and also to share ideas on how to best define HEW missions so as to meet the committee's needs without placing an undue burden on your staff.

Based upon these discussions and last year's experience, we have developed a revised set of end-purposes for health and education expenditures. In order for this information to be incorporated into the subcommittee's hearings, we will need a display of the distribution of each appropriation item according to end-purposes shown in the attached tables by February 11.

We look forward to your interest and support in this important endeavor.

With best regards,

Sincerely,

John L. McClellan
Chairman

Warren G. Magnuson
Chairman, Labor-HEW Subcommittee

Lawton Chiles
Member

EDUCATION

A. FINANCING EDUCATIONAL SERVICES Not Otherwise Available-Grants to States, Districts and Institutions.

1. ADULT Education
2. BILINGUAL Education
3. DISADVANTAGED (Include INDIAN Educ.)
4. HANDICAPPED and LEARNING DISABILITIES
5. VOCATIONAL
6. Other Special Educational Needs (Environmental educ., metric, etc.)
7. SUPPORTIVE SERVICES (LIBRARIES)
8. General Financial Support

B. ELIMINATING FINANCIAL BARRIERS To Education By Providing Financial Aid to Students.

1. POVERTY ORIENTED (NEEDS TESTED)
2. GENERAL AID

C. Improving the CAPACITY of State and Local Education Systems

1. ADMINISTRATION, MANAGEMENT and PLANNING
2. IMPROVED INSTRUCTIONAL METHODS -- Innovations, Demonstrations, Knowledge Dissemination, Curriculum Development

3. DEVELOPING INTEGRATED SCHOOL SYSTEMS

4. TRAINING of EDUCATIONAL MANPOWER

5. FACILITY CONSTRUCTION

D. KNOWLEDGE DEVELOPMENT (Basic Research and Statistics) -- Assess the Status and Progress of American Education

HEALTH

A. KNOWLEDGE DEVELOPMENT

1. BASIC RESEARCH

2. APPLIED RESEARCH - TREATMENT METHODS for Physical and Mental Health Problems.

3. APPLIED RESEARCH - SERVICE SYSTEM OPERATION, EFFECTIVENESS

4. STATISTICS and HEALTH STATUS MONITORING

B. PREVENTION and PROTECTION

1. OCCUPATIONAL Health

2. ENVIRONMENTAL Health

3. PERSONAL Health (Include Disease Control, Immunization)

4. HEALTH EDUCATION

5. PRODUCT SAFETY(FDA)

C. FINANCIAL DIRECT MEDICAL CARE

1. MEDICAID/MEDICARE

2. GRANTS For SERVICE PROVISION (CHCs, CMHCs, MCH, etc.)

3. Care at FEDERAL INSTITUTIONS

D. IMPROVING THE CAPACITY OF SERVICE SYSTEMS

(Private, State, Local)

1. ADMINISTRATION, MANAGEMENT, PLANNING and REVIEW (PSROs,UR)

2. DISTRIBUTION OF SERVICE (Migrants, NHSC, other special groups)

3. INNOVATIVE METHODS OF SERVICE ORGANIZATION (HMOs, Demonstrations)

4. Develop SKILLED MANPOWER

5. FACILITIES CONSTRUCTION

THE SECRETARY OF HEALTH, EDUCATION, AND WELFARE
WASHINGTON, D.C. 20201

FEB 24 1976

The Honorable Warren G. Magnuson
Chairman, Subcommittee on
Labor-Health, Education, and Welfare
Committee on Appropriations
United States Senate
Washington, D.C. 20510

Dear Mr. Chairman:

Thank you for your letter of January 22, 1976, which you signed jointly with Senator McClellan and Senator Chiles. Please accept my apology for the delay in responding. I am pleased to cooperate with the Appropriations Committee in its initiative for framing program costs in terms of functional categories. I asked Mr. John D. Young, the Department's Assistant Secretary, Comptroller, to prepare the reports as you requested.

I am enclosing a summary of the information requested on education and health program costs at the FY 1976 appropriation levels and at the FY 1977 budget levels. Detailed back-up for the summary is being provided directly to Senator Chiles' staff.

If I can be of further assistance, please let me know.

Cordially,

David Mathews

Secretary

HEW Appropriated Level (FY 1976) and Budget Estimate (FY 1977) Categorized for Education and Health Functional Purposes in the Format Requested by the Senate Appropriations Committee ($ in thousands)

	FY 1976 Appropriated Level	FY 1977 Budget Estimate
Health		
A. Knowledge Development		
1. Basic Research	$ 681,310	$ 650,467
2. Applied Research - Treatment Methods for Physical and Mental Health Problems	1,441,813	1,373,245
3. Applied Research - Service System Operation, Effectiveness	42,646	42,105
4. Statistics and Health Status Monitoring	88,468	86,947
B. Prevention and Protection		
1. Occupational Health	42,909	40,700
2. Environmental Health	---	---
3. Personal Health (Include Disease Control, Immunization)	431,844	456,423
4. Health Education	600	300
5. Product Safety (FDA)	207,805	223,105
C. Financial Direct Medical Care		
1. Medicaid/Medicare	8,958,526	10,042,094
2. Grants for Service Provision	1,212,906	878,740
3. Care at Federal Institutions	198,505	191,549
D. Improving the Capacity of Service Systems (Private, State, Local)		
1. Administration, Management, Planning and Review (PSRO's, U.R.)	140,257	138,488
2. Distribution of Service (Migrants, NHSC, other special groups)	63,065	47,259
3. Innovative Methods of Service Organization (HMO's, Demonstrations)	91,635	75,479
4. Develop Skilled Manpower	687,315	522,338
5. Facilities Construction	236,710	128,495
Health, Total	$14,526,314	$14,897,734

HEW Appropriated Level (FY 1976) and Budget Estimates (FY 1977) Categorized for Education and Health Functional Purposes in the Format Requested by the Senate Appropriations Committee ($ in thousands)

	FY 1976 Appropriated Level	FY 1977 Budget Estimate
Education		
A. Financing Educational Services Not Otherwise Available-Grants to States, Districts and Institutions		
1. Adult Education	$ 65,558	$ 62,539
2. Bilingual Education	81,118	78,891
3. Disadvantaged (Include Indian Educ.)	1,970,300	1,829,560
4. Handicapped and Learning Disabilities	313,003	327,656
5. Vocational	209,195	196,905
6. Other Special Educational Needs	81,427	59,362
7. Supportive Services (Libraries)	212,697	151,349
8. General Financial Support	1,073,394	675,906
B. Eliminating Financial Barriers to Education by Providing Financial Aid to Students		
1. Poverty Oriented (Needs Tested)	1,507,162	1,397,043
2. General Aid	1,017,607	440,491
C. Improving the Capacity of State and Local Education Systems		
1. Administration, Management and Planning	424,558	378,286
2. Improved Instructional Methods	210,777	172,476
3. Develop Integrated School Systems	192,414	196,608
4. Training of Educational Manpower	125,766	109,555
5. Facility Construction	36,522	31,900
D. Knowledge Development (Basic Research and Statistics)--Assess the Status and Progress of American Education	73,599	84,076
Education, Total	$7,595,097	$6,192,603

BASIC GRANTS LEVELS

Senator BROOKE. Before you pass Emergency School Aid, I want to commend you on that.

Secretary MATHEWS. I was hoping we could get a chance to dwell on that. I was going to talk about 15 minutes on that.

Senator BROOKE. Well, sometimes we don't commend you, and this is one time when I wanted to go on record to commend you for increasing that.

I see you held basic grants at the same level, which is good, because there were some problems there, and you've increased the civil rights training advisory service by $8 million, which will be very helpful. I just want to commend the Department and you particularly, Mr. Secretary.

Secretary MATHEWS. We are delighted you noticed, Mr. Senator.

HIGHER EDUCATION

Legislative authority for virtually all of the higher education programs under this appropriation expires at the end of June 1976. However, the budget contains appropriation requests based on the administration's recommended legislation.

STUDENT ASSISTANCE

Our 1977 budget request for higher education would maintain the administration's policy of concentrating Federal resources on student aid. This policy places priority on assuring that all qualified students have funds to obtain at least a low-cost postsecondary education.

The basic grant program will be the principal form of Federal aid, providing a floor of assistance to needy students. The estimate of $1.1 billion is based on the estimate of what it would cost to fully fund all 4 years of college for eligible students.

Additional State assistance to students will be stimulated through continued incentive grants to States to encourage scholarship support.

The guaranteed student loan and college work study programs will be continued.

Duplicative student assistance programs are proposed for repeal, in particular the supplemental educational opportunity grant and national direct student loan programs. These programs are duplicative of either the basic grant or guaranteed student loan programs.

Senator MAGNUSON. What is the figure on the college work study program? Is that under last year's?

Secretary MATHEWS. $250 million. It's the same figure that the administration has submitted for some time. It's $250 million.

Senator MAGNUSON. Is it under the appropriation level?

Secretary MATHEWS. It's under the appropriation level.

Senator MAGNUSON. How much?

Secretary MATHEWS. The appropriation level is $390 million, as opposed to $250 million.

Senator MAGNUSON. That's way down, isn't it?

Secretary MATHEWS. It is, sir.

Senator MAGNUSON. The work study program.

Secretary MATHEWS. Yes, sir.

Senator MAGNUSON. Is the reason for that because you think BEOGS is sufficient?

Secretary MATHEWS. In terms of policy, we are making a rigid commitment to BEOG, but the administration position was to continue to support work study, at the level at which it supported in previous years.

In other words, to answer the question, I don't think there was any feeling——

Senator MAGNUSON. Well, this committee has been very generous in commitments to BEOG, and we've had to work slowly because now we've got it to where it can be the 4 years. But we found even during the transition period, or even now that the work study program served a great purpose.

Secretary MATHEWS. Well, I'd agree with you, yes, sir.

Senator MAGNUSON. And I think they still do that. I believe we're going to have to check pretty carefully on that.

Secretary MATHEWS. I would say that the work study programs are very useful.

OTHER HIGHER EDUCATION

We will continue the priority we have given to the program to strengthen developing institutions which is focused on institutions enrolling a large percentage of minority students. We are asking for $110 million, virtually the full legislative authority.

Generally, for the remaining higher education programs we are asking either that they be reduced or terminated. In the latter category, the principal terminations would be Veterans Cost of Instruction, Aid to Land Grant Colleges, and University Community Services.

Senator MAGNUSON. Wait a minute. Don't pass over here. You want to cut out aid to land grant colleges completely. Is that your position?

Secretary MATHEWS. That is my position, sir.

Senator MAGNUSON. Is Alabama a land-grant college?

Secretary MATHEWS. No, sir. Only in the original sense it was, but this is a small amount of money. It is distributed to the States.

Senator MAGNUSON. Well, I know what it is.

Secretary MATHEWS. And it was for a program that was very important in 1862.

Senator MAGNUSON. Well, here again, there ought to be some move to abolish the legislation. Here the legislation says you should make these grants. There it is on the books. So you're legislating, you're killing, you're repealing the legislation by recommending no money for it.

Secretary MATHEWS. We'll do both, sir, we'll do both, because this is a program that was passed in 1862, if my memory serves me correctly.

Senator MAGNUSON. That's why it stood the test of time.

Secretary MATHEWS. And it's proved itself, and now we can get into something else.

Senator MAGNUSON. What do you mean by university community service?

Secretary MATHEWS. This is a program by which universities would interact with the local community and find out what they needed.

Senator MAGNUSON. And this was a very controversial program.

Secretary MATHEWS. It didn't work. It did not work according to the evaluations.

Senator MAGNUSON. Well, some people said it was working and others said it wasn't.

Senator BROOKE. Before you move to higher education, Mr. Secretary, I can't commend the proposal on supplemental opportunity grants, which is zero. The 1976 appropriation was $240 million. You zeroed it in 1977, and then you came down to student aid direct loan with Federal capital contributions from $321 million to 0.

In other words, you're terminating that program. Loans to institutions, 2 million. You're terminating that program.

What are you doing to higher education?

Secretary MATHEWS. All right. The SEOG program is really duplicate, and we feel that the BOG program replaces it. Work study we continue.

Senator BROOKE. Can you have one without the other, the basic opportunity without the supplemental opportunity grants?

Secretary MATHEWS. The other line increases that you see, are places where we have sufficient funds to continue, for example, in defaulted loans. There is a figure, I am not looking at it now, but we've already got money to pay for that, so we're not requesting additional money.

It's not a policy decision or an abandonment of the program. It's that we have a sufficient reserve to pay our default rate.

Senator BROOKE. I conducted some hearings in Boston. Mr. Dirks——

Senator MAGNUSON. Well, they recommend zero in supplemental opportunity grants and they recommend zero in Federal capital contributions.

Senator BROOKE. Well, that's the point. That's the student loan program.

Senator MAGNUSON. And we appropriated $321 million.

Senator BROOKE. We had some findings which will be included in our report. But the program is working and working well. What's your justification for that?

Secretary MATHEWS. On the direct loan?

Senator BROOKE. Yes.

Secretary MATHEWS. That is one of the programs we described as duplicative of the policy direction to go to the student BOG's program and the guaranteed student loan would be the major loan program of the government under this.

Senator BROOKE. And that's funded at what level?

Secretary MATHEWS. The figure we have on that is about $400 million.

Senator BROOKE. And how much was it funded at in 1976?

Secretary MATHEWS. $452 million.

Mr. MILLER. There's enough money in the budget to cover the full demand.

Senator BROOKE. You're still cut it $321 million. You're not saying that you can get under guaranteed student loan.

Secretary MATHEWS. Well, the $300 million comes in part because we're not requesting an amount to cover defaults on loans, and it comes because it's $52 million that we are not requesting on the last program that you inquired about.

Mr. YOUNG. Senator Brooke, in those cases we get carryover funds from previous years. So those minus numbers don't look like that.

Also, on the direct loan program, that's a revolving fund, as you recall, and I'm not sure you can carry it out at quite the level that it is now. But still, if the universities did a little bit better on collections, that revolving fund could be bigger and continued.

Senator BROOKE. Yes, but you know what the record is.

Secretary MATHEWS. It's not spectacular.

Senator MAGNUSON. All right, we'll find out who handles that downtown, the direct loan, because we've had a lot of arguments about this, and we've had some problems with the banks.

Secretary MATHEWS. Yes; we do have.

Senator MAGNUSON. We've had some problems that bankruptcy rates have gone up and up and up and there hasn't been a single case tried that I know of, or at least last year, in Federal court, a civil suit to collect the money.

Secretary MATHEWS. I know we have just proceeded to prosecute——

Senator BROOKE. Well, it's a difficult time, Mr. Chairman, of high unemployment, high inflation. These students are suffering like everybody else, and how can they make the money to pay back these loans. It's a serious problem for them.

Senator MAGNUSON. Although the banks are guaranteed, you'd think they would like these loans, but they don't want them.

Secretary MATHEWS. No, sir.

Senator MAGNUSON. That's what they call slow paper.

Secretary MATHEWS. That's right.

Senator MAGNUSON. They want some paper where there's action.

Secretary MATHEWS. Well, one thing is to look to institutions that deal more with long-term paper because we're dealing with banks that are short-term paper institutions for 4 year-loans.

Senator BROOKE. Are you going to have enough money here to do the job? You're still $321 million below this year. If you were substituting or transferring that to insured or guaranteed loans, I could understand it, but you're not doing that. You're cutting out one program and you're saying it should go into guaranteed loans, which you're funding at the same level as funded in 1976. So students won't be able to go there.

Secretary MATHEWS. Well, if you take the $1.8 billion, plus the reserves, it's my understanding that those two figures added together allow us to continue the same program we had last year.

Senator BROOKE. At the same level?

Secretary MATHEWS. And the BEOG's level to increase.

Mr. YOUNG. If you take the number minus the forward carryover, it would be the same level, plus the problem we have on BEOG's. We have underestimated student participation. We will have to come to Congress and ask for additional funds, significant funds both for this year, next year, and the following year.

When you add what we need to make full funding in terms of BEOG's, the number for the student assistant programs will be well above the number here.

Senator BROOKE. More students are going to need loans than ever before.

Mr. KURZMAN. The program caught on the first 2 years. It was under earnings this year.

Senator MAGNUSON. All right, let's go along here.

NATIONAL INSTITUTE OF EDUCATION

Secretary MATHEWS. All right, sir. I wanted to tell you about the NIE. I know you have had some question, but as I told you in your office when I first came we've got a truly first rate man there, a chance to do a good job.

Senator MAGNUSON. Well, here's where the chairman might save you a little of money. You're for saving, aren't you.

Secretary MATHEWS. We are, sir. But as you're asking me to earnestly reconsider some matters I'm asking you to look at the potential of this institute to do some good.

Senator MAGNUSON. Well, have that fellow ready, the director, the new one, tell him to have the list of the grants, laying out, and what he calls them, in English, so we can understand them in layman language.

Secretary MATHEWS. We will, sir, and we'll ask you——

Senator MAGNUSON. So I can read them on the Senate floor.

Secretary MATHEWS. Very good. Very good, sir. All right, sir. Now, move on to Social Security——

[Pause.]

Senator MAGNUSON. We know about the President's proposal and we've got to have some legislation, and there's no appropriation involved here at all. And there's got to be some legislation that would——

SUPPLEMENTAL SECURITY INCOME PROGRAM

Secretary MATHEWS. Well, the part that I'm going to tell you about is the part where we do need an appropriation.

Senator MAGNUSON. And that's the SSI.

Secretary MATHEWS. Right.

Senator MAGNUSON. All right. Now we're getting down to appropriation business.

Secretary MATHEWS. We are estimating that Federal benefit payments will increase from $4.5 billion in 1976 to $5.2 billion in 1977. This will permit State supplementary funds to decrease from $1.3 billion to $1.2 billion.

Senator MAGNUSON. How does that happen.

Secretary MATHEWS. The increase in the Federal Government and the improvement in the focus of the program—what are the figures on the population surge?

Mr. YOUNG. It's 4.1 million.

Senator MAGNUSON. This is a pretty topical subject around here and the House is working on it and we're going to do the same. The Senator from Massachusetts and I intended to go into it last fall, but we

just never got to it. And in the meantime Cardwell was testifying around other committees so we got the information.

Mr. MILLER. One sentence on that, Mr. Chairman, as the Federal benefit increases, this decreases State's need to supplement in order to hold benefits level.

Senator MAGNUSON. So we can understand it.

Secretary MATHEWS. The total number of beneficiaries will go up from 4.6 million to 5.2 million.

We expect the following management improvements in this particular program——

Senator MAGNUSON. Case error rates are projected to drop from 24 percent to 15 percent.

Secretary MATHEWS. Right, sir.

Senator MAGNUSON. Now are these in the nature of illegal payments?

Secretary MATHEWS. No, sir.

Senator MAGNUSON. Are they fraud payments?

Secretary MATHEWS. No, sir. I think we need to understand the problem here because we use the term error, and I really think it's an improper use of the word. What you're doing here is not adding two and two and getting five. Rather, the caseworker, looks at the client and says according to this long list of specifications, we think you qualify for $52 worth of benefits.

Now then, to make sure that we are carefully checking, we send a group of auditors to look at the same standards and the same individual and make judgments.

Moreover, there may be changes in your status at a given time. That is, at the first of the month when you come in you may not have any income and you may, in fact, be entitled to $52. On the 15th day of the month, you may get some income. That would show up in the subsequent report.

But really, what we are reporting as errors are really the audit scrutinies of these programs, and to report that you're going to have discrepancies in a program where people's status is going to change and where you are making kind of referee calls over and against a complex list of often changing categories in an individual State is not to report anything other than what you just reasonably expect out of common sense.

Senator MAGNUSON. Well, I know you're comparatively new on this, but I want to ask Charley, are we cleaning this up?

I don't know whether you recall this, but when it first started, we had so many people in my office in Seattle, you couldn't get them in the hall. But most of those cases were—they were delays, or they were eligible and they were turned down.

Now some of the things we were thinking about were where they weren't eligible and they got the money, or got some money.

Senator BROOKE. Will that error rate ever go down below the 15 percent?

Secretary MATHEWS. To be honest with you, by judgment is that in this kind of program and it is not resonable to think that the discrepancy rate will disappear.

Senator BROOKE. You amend it from error to discrepancy?

Secretary MATHEWS. I think a proper use of the language would be the latter term. I think that what we are experiencing now can be substantially improved and we will improve it. We are recertifying over 4 million of these cases, you know, going back through them and the management of this program is improving. We are requesting additional personnel to attend to this problem but I think that we should not mislead people, nor should we improperly state the nature of what's going on. And I would want to clarify that if I could.

Senator MAGNUSON. Well, this is a tough one to tackle. You can't blame it all on bureaucracy or blame it on the Department or blame it on the laws. It's just that everybody's got a finger in this thing.

As I say——

Mr. YOUNG. Senator, I would like to submit and explain the characteristics of this program.

Senator MAGNUSON. Well, we'll have Cardwell up here to explain the thing. Well, we made a request and we got a letter here from—Mr. Young.

I'll tell you what we'll do. We won't put the letter in at this point. We'll put it in when we get to this subject.

Mr. YOUNG. Mr. Chairman, before each witness comes you'll have other reports from the Secretary in terms of what we're doing on the so-called misuse, abuse problem.

Senator MAGNUSON. These legislative proposals like the block grants plan come up every year. They look all right on paper, but with a closer look, we usually find it's a mask for reducing support to the schools. Does this new proposal have any safeguards to prevent a lessening of Federal aid?

Secretary MATHEWS. The block grants are not being proposed in order to reduce Federal expenditures, Mr. Chairman. And in fact, the 1977 funding levels are generally greater than 1976. Also, it is my understanding that in the health block grant, the authorization level will go up $500 million in 1978 and another $500 million in 1979. In the case of the social services grant, we are proposing to distribute the entire $2.5 billion ceiling—some States currently don't receive their full allotment because they don't put up their required matching share. In education, we are proposing a funding level which is just about the same as the 1976 appropriation.

No, I wouldn't say that the block grants are intended to reduce Federal funding. By eliminating required matching, reducing the number of categories, and eliminating many of the restrictive provisions in existing program, we think that the Federal resources will in fact be more effectively utilized than at present.

Senator MAGNUSON. Last year the HEW budget proposed that many health programs be phased out—it was said that the States could handle them. We rejected the proposal because many States were in a more tenuous financial situation than the Federal Government. Now, we have a similar proposal before us again this year.

1. What leads you to believe that the States will be more able to pick the health programs up this year?

2. What steps have you taken to insure that no services would be lost if your budget were approved?

3. What specific steps have you taken that will enable the States to fund these programs?

Secretary MATHEWS. The block grant for health includes many of the programs you are referring to, I believe. As you know, though, we are proposing $10 billion for the program, which is more than 1976. It is our view that within this amount, the State should be able to plan a health program which would provide essential medical services to those in need. But we are not defining the precise services which a State would have to provide or provide what kind of a delivery mechanism it must use. That would be up to the States to decide. There are earmarks in the legislative proposal, though, to be sure that certain priorities are achieved—primary health care for the poor, for example.

Senator MAGNUSON. Nearly 50 percent of all rescissions and deferrals sent to Congress involve HEW programs; so far we have rejected every rescission proposal. Aren't you ignoring the intent of Congress and abusing the new Budget Act by constantly asking for rescission? Doesn't this flow of rescission and deferral requests harm the effectiveness delays in allocating funds?

Secretary MATHEWS. No. Mr. Chairman, we are not ignoring that intent of Congress. We are carrying out the provision of the Budget and Impoundment Control Act as Congress intended. It is true that most of the President's rescission proposals for HEW have not been adopted; but, that doesn't mean that we are abusing the act. It simply means that there is a disagreement between the Congress and the administration.

The rescissions and deferrals probably do cause uncertainty on the part of the recipient community, just as delays in enacting HEW appropriations cause an equal amount of confusion. If I am not mistaken, for example, nearly 6 months of this fiscal year went by before the health and welfare bill was sent to the President! And I think a similar situation has existed in previous years.

Senator MAGNUSON. You took over as Secretary last year. In fact, you probably dropped right into the middle of the budget debate between the agencies you represent and OMB. To what extent were you involved in formulating the education budget? Health budget? Do you see any specific problems or weaknesses in it that you would personally like to remedy?

Secretary MATHEWS. While I wasn't sworn in until after a great deal of the preliminary work on laying out the issues had been done, the Department's proposals and recommendations to OMB were my decisions. And, we—myself and my principal advisers—got a full hearing with the President in resolving 1977 budget issues.

I don't have any specific recommendations to make on problem areas in the process. Although, there is one area that does interest me a great deal. I believe that it is important to have more dialogues with people and groups who are affected by our programs in order to get their reactions and input.

Senator MAGNUSON. On December 5, 1975, you stated in a press release, "One of my major objectives as Secretary is to insure that every HEW dollar is channeled to its target population in a human

and efficient manner." What progress are you making in the Office of Investigations, especially, in your search for a Director?

Secretary MATHEWS. The office has been set up and an acting director has been named to get operations underway while recruitment for the director is going on. A number of well qualified individuals are under consideration for the post and we expect that we will be able to make a selection in the near future.

Senator MAGNUSON. The issue of fraud and abuse is important to us. Last year both the House and Senate asked for your views and recommendations on this. We are looking forward to working with you in the months ahead. To what extent will you be looking at fraud within HEW? In other words, will you address the problem of your own employees involved in the misuse of funds?

Secretary MATHEWS. We appreciate your interest and the help your committee is providing us. The responsibilities of the new office of investigations will not be limited to just the recipients of HEW programs. Our own internal operations will also be subject to the office's review.

Senator MAGNUSON. In December one of the reasons the President gave for vetoing the fiscal year 1976 Labor-HEW appropriations bill was that it would increase Federal employment by 8,000 people. Six thousand of these jobs were conversions of temporary social security employees to permanent employees. Now the fiscal year 1977 budget comes to us with a request that 6,000 2-year term positions be made permanent and that an additional 2,000 positions will be needed at the Social Security Administration. What is the reason for this abrupt change of position?

Secretary MATHEWS. The issue on the Labor-HEW bill was not the increase in positions, per se, but the mandating of additional staff, where needs had not been documented or justified. Where it can be demonstrated that additional staff are necessary to carry out departmental responsibilities, they are requested. But, it is our view that new positions added in appropriations frequently have not been adequately reviewed or justified. We just don't believe that it is appropriate to mandate additional Federal staff.

Regarding the social security positions, we came to the conclusion that it would be more effective to utilize permanent positions than 2-year term employees and that additional staff were necessary for SSA to carry out its responsibilities.

Senator MAGNUSON. What is the total amount of fiscal 1977 budget requests for Older Americans Act programs? How does this compare with the amount voted by Congress for programs under the Older Americans Act in fiscal 1976?

Secretary MATHEWS. We are requesting about $193 million for programs under the Older Americans Act in 1977. This compares with roughly $236 million authorized so far in fiscal year 1976 appropriations. This includes the amounts authorized under the continuing resolution for those programs which were not authorized at the time you considered the regular Labor-HEW 1976 bill. You have before you now a supplemental request from us for those programs now that they are authorized.

I should point out that most of the difference between the $193 million we are requesting in 1977 and the $236 million you have so far

authorized is for nutrition program. We can maintain a $150 million program level in 1977 with only $88 million in new budget authority.

Senator MAGNUSON. When do you think Federal financing might be needed for the social security program?

Secretary MATHEWS. We have proposed a .3 percent social security tax increase with the 1977 budget to help out with the financing problem. Substituting general tax financing to overcome trust fund deficiencies as you seem to be suggesting, though, in my view is not the solution. One of the problems with that approach is that there could be a reluctance in Congress to increase general tax revenues to pay for the financing. That would only exacerbate the Federal deficit. If no additional financing is legislated for the social security trust funds, the disability insurance trust fund will be in deficit by 1980. The other SSA trust funds will have at least a small surplus until the mid 1980's.

Senator MAGNUSON. Do you have any plans to merge local welfare and vocational rehabilitation offices? [Background: Although officially denied, complaints have been received from Washington State saying that vocational rehabilitation clients would be forced to share the same space with welfare recipients. This might adversely affect services in both programs.]

Secretary MATHEWS. The Department does not, to the best of my knowledge, tell the States how to organize and where they should locate their local human services activities. In the situation you have in mind, we have checked with the regional office and they have not attempted to interfere in this matter.

Senator MAGNUSON. During Under Secretary Lynch's recent visit to Seattle, she stated that the bureaucracy should be leaner. She said that she would start the process by cutting her own 70 person Undersecretary's staff. Does your 1977 budget reflect this recommendation?

Secretary MATHEWS. We are proposing some reductions in the 1977 budget in our overhead in order to free up some additional positions in the General Counsel's Office to work on social security cases. The review that Mrs. Lynch is making of her own staff and the functions that are assigned to her office are separate, though, from our 1977 budget recommendations. I might point out that most of the staff in her office is the investigations function, which will definitely not be reduced. She will be the Department's witness when we come up here to testify on the 1977 departmental management budget; and, I am sure she would be happy to discuss that further with you then.

Senator MAGNUSON. What are the Departments of Labor and HEW doing to see that annual plans for the employment service, the work incentive program, vocational education, vocational rehabilitation, and social services provided under title XX of the Social Security Act are properly coordinated?

Secretary MATHEWS. The staffs of Labor and HEW are working on this. I met with former Secretary Dunlop recently and we have agreed to discuss problems of coordination of all our programs on a continuing basis at the staff level. This discussion is going on now. I am confident it will continue under new Labor Secretary Usery. The program staff who will be appearing before you in subsequent hearings should be able to give you more information on what steps are being taken to coordinate those various programs.

I might mention, too, that the Federal regional councils in each of the regions work to coordinate these programs. Furthermore, title XX law requires the State plan to describe how it relates social services to manpower programs.

Senator MAGNUSON. What have you, as HEW Secretary, done about facilitating the issuance of proposed regulations in a timely manner?

Secretary MATHEWS. This has been a subject of great concern and highest priority to me. A specific step I have recently taken is to set up a special office in my immediate office to track regulations to make sure that they do get out in timely fashion and are responsive to legislative intent.

Senator MAGNUSON. How does the Department enforce requirements that notice of proposed rule-making be published no later than 3 months following enactment of enabling legislation?

Secretary MATHEWS. We have had problems; but I hope that with our recognition of the severity of the problem, we will be able to keep on top of it. The new office which we set up will follow up with the HEW's program office to make sure the regulations are expedited.

Senator MAGNUSON. As of December, there were 68 sets of proposed regulations received in your office, several of which have been there since June and July of 1975. What actions can you propose to speed up the process?

Secretary MATHEWS. I don't know how many there were then, but I think that most of the backlog has been cleared out now. In the future, the new office that has been set up should keep the process flowing smoothly.

Senator MAGNUSON. What procedure has been established to assure that regulations are responsive to congressional intent?

Secretary MATHEWS. The multiple reviews which are made of regulations in the Department as well as the public comment period should assure that they are responsive.

Senator MAGNUSON. What overall recommendations would you make to assure that the regulation process becomes more reasonable and efficient?

Secretary MATHEWS. We hope that we have already taken steps to improve our part of the regulation process. The biggest aid that Congress could give us would be to refrain in many instances from passing such detailed legislation. To the degree that Congress mandates how programs will be organized, develops intricate eligibility provisions and the like, to that same degree will regulations be delayed and controversial. Block grants are an effort to greatly simplify this process.

Senator MAGNUSON. As you know, Saint Elizabeths Hospital has lost its accreditation because of the constant shifting of funding responsibility between HEW and the District. If the hospitals all over the country have to abide by HEW rules and regulations, why can't you see to it that Saint Elizabeths sticks to the rules, too?

Secretary MATHEWS. As I understand the situation, the factors leading to the loss of accreditation at St. Elizabeths Hospital were many. And certainly, the debate over who should have jurisdiction over the hospital had an impact on it, but that issue was not the only one.

I do agree with you that federally run hospitals must meet the same standards as other facilities. And, we are requesting additional funds and staff for St. Elizabeths Hospital to bring it up to standard.

Senator MAGNUSON. Coming from the education community, you must have a good understanding of the problems that exist in the schools. What do you consider to be national problems? In other words, areas where the Federal Government must share responsibility with the States and local schools?

Secretary MATHEWS. Well, I think my views on that run pretty close to what the Constitution says on education. As far as the Federal role in education is concerned, I think we have a responsibility to identify problems of inequity—handicapped and disadvantaged, for example—and to help the States in overcoming inequities. And the 1977 budget focuses on this goal through our block grant proposal in elementary and secondary education, funding of emergency school aid projects and basic opportunity grants funding in higher education.

Senator MAGNUSON. Aside from some of the legislative proposals in the education budget, what would you consider to be the major thrusts?

Secretary MATHEWS. I think that some of the items mentioned a moment ago—basic grants, emergency school aid and the research conducted by the National Institute of Education—are important initiatives. Additional staff for the Office of Education to work on student aid problems is another.

Senator CHILES. Mr. Secretary, why are you proposing to eliminate impact aid for the B students whose parents work but do not live on Federal property. Doesn't the presence of Federal property deprive the school district of tax revenues it would receive if the parents were working in private businesses?

Secretary MATHEWS. To the contrary, Senator Chiles, the historical record has been that the presence of the Federal establishment has attracted jobs and business, which creates more tax revenues to the local jurisdiction than would have been the case without the presence of the Federal facility. What our proposal does is to continue the payments where parents don't contribute to the local tax effort because they live on the Federal property—the A's. But we are not proposing to fund the B's, whose parents are like any other parent in the school system, paying their share of local taxes. I just don't believe that giving another payment to the local school system for this group is justified.

Senator CHILES. Mr. Secretary, in two important programs—handicapped and vocational education—you have proposed turning over the entire responsibility to the States. Even if it might make sense for the States to administer the services components of these programs along with their regular services, wouldn't it be more reasonable to keep the research and development components at the Federal level, so that new ideas could be tried out and spread to the different States?

Secretary MATHEWS. I don't think that situation here is quite the same as in biomedical research, for example, where the Federal Government clearly has the leadership role. In the first place, most of the money designated as vocational research is already being administered at the State level. We do approve individual projects, but the States already have most of the initiative. The handicapped education special projects which would also be folded into the education block grant are currently administered by the Office of Education; but, I don't see any reason why the States couldn't assume responsibility as they are mainly service projects or training. I continue to see a strong central

role for the Department in doing research, though, through the National Institute of Education and the handicapped deaf-blind centers—which would not be affected by the block grant—and through the collection and dissemination of important research findings.

[Subsequent to Secretary Mathew's testimony, the Administration education consolidation bill was amended to provide for the continuation of funding at the Federal level for the following special projects under the Education for the Handicapped Act: (1) Deaf-blind Centers; (2) Regional Resource Projects; (3) Captioned Media; and (4) Innovation.]

Senator CHILES. Mr. Secretary, you have proposed saving money in this program by imposing an arbitrary limit of 7 percent on hospital rate increases and 4 percent on doctors' services. Since these limits are only about half of the projected actual cost increases, who is going to pay the difference—the patients, the States? Wouldn't it make more sense to continue ahead with programs like prospective rate review and utilization review to hold down cost increases at their source, rather than just shifting the burden or inducing doctors not to accept medicare patients?

Secretary MATHEWS. I think that the problem has to be attacked at its source as well as reducing costs through such mechanisms as utilization review.

It is possible that some doctors or providers might turn medicare patients away or that some medical costs might be passed on to other patients if there are limits on the amount medicare will reimburse; but, medical costs are continuing to increase faster than any other sector of the economy. And we believe that some form of restraint must be enacted if we are going to have any kind of major impact.

Senator CHILES. Would you give us an idea of where you have gone in the last year with your various programs aimed directly at cost control? Have there been any real successes? You are asking for $2 million of new money for rate review experiments. Where do you expect to spend this and how soon could we expect to see some results?

Secretary MATHEWS. The PSRO program is relatively new, Senator, and therefore it is too soon to evaluate its success. We do have some preliminary results, though, that show that hospital utilization levels can be reduced by the utilization review made by PSROs. We believe that the program can and will have a significant impact on utilization of medical services, with resultant lower costs to the Federal Government.

Senator BROOKE. A recent House report indicates that approximately half of the operations which are paid for through medicaid and medicare are unnecessary amounting to an excess cost to the Government of some $1 billion. Are you considering revising departmental policy to correct these apparent abuses?

Secretary MATHEWS. I wouldn't say that our policy encourages unnecessary surgery, Senator. It may be that some doctors have taken advantage of medicare and medicaid financing by performing surgery which was not needed. In other cases, there may be an honest difference of medical opinion as to whether the surgery was or was not required. We are requesting an increase in the budget for the PSRO program, which we hope will offer proper review of medical cases, and that you and the other members will support.

Senator BROOKE. Congress recently passed an Education for all Handicapped Act (Public Law 94-142). There are 7 million handicapped children in the United States. About 1 million get no public education at all. Do you intend to follow up on this commitment with a new budget request.

Secretary MATHEWS. A request of $235 million has been proposed for the handicapped program in the Office of Education equal to the 1976 appropriation in the 1977 budget. We think that it is extremely important that greater recognition be made of the special problems and barriers facing the handicapped in seeking education, but we don't believe that the burden of financing the additional costs should fall primarily upon the Federal government. The State can and should assume a greater responsibility in this area. This is clearly stated in the law.

Senator BROOKE. I note recent news articles which describe HEW "as wide open to fraud." These are based on a study by a House Government Operations Subcommittee which warns of fraud and program abuse at your agency. What are you doing about this?

Secretary MATHEWS. It is potentially a very serious problem, one which concerns me a great deal. With the Congress help, we are taking specific steps to increase over central surveillance through a new Office of Investigations, which is reporting directly to the Under Secretary. Among other efforts, we have requested increased staff to monitor our student aid and medicaid programs. And, the Social Security Administration is engaged in vigorous efforts to improve its systems to assure that SSI payments are as accurate and equitable as we can possibly make them.

Senator BROOKE. The report also states that your Office of Investigative Security has a 10-year backlog of uninvestigated cases. How do you plan to cope with this? What areas are the cases in? In what areas do you anticipate you will have additional cases?

Secretary MATHEWS. We are increasing the staff resources in the new Investigations Office; but I don't have any information on the kinds of case load currently pending. Perhaps, Mr. Young does.

Mr. YOUNG. I don't have any specific information with me either Senator. But this subject will come up again when you consider funding for the Office of Investigations in the Departmental Management appropriation. We will have the information for you then.

Senator BROOKE. Do you foresee the Federal Government becoming involved in the controversy over malpractice insurance rates: If so, how?

Secretary MATHEWS. We are affected by increasing malpractice insurance costs because they eventually get passed on the use in the form of high medicaid and medicare bills. But, the question of Federal involvement in the problem is difficult to answer because the licensing of medical personnel and regulation of insurance underwriting is a State responsibility. I don't have a good answer for you, except to say that we are still studying it.

Senator BROOKE. Under your proposed education consolidation, I understand you plan to call for Staes to use three-quarters of the funds for education of the disadvantaged or handicapped. It is conceivable that a State could spend all of its disadvantage set-aside for, say, adult basic education and none on title I program? How much of the money

will go for disadvantaged—however you define that work—and how much for handicapped? Will there be any provision for holding States harmless from one year to the next?

Secretary MATHEWS. I don't think that it would be possible, Senator Brooke for a State to spend all of its block grant money in the disadvantaged categories on adult education. It is my understanding that a minimum of 75 percent of the block grant must be spent for disadvantaged children, including handicapped. Adult education would be one of the programs eligible for funding with the remaining 25 percent. The formula which is under discussion would have some effect on redistribution funds among States; however, one of the provisions in the proposed legislation would limit the amount of decrease or increase in any given State in order to provide hold harmless protection.

Senator BROOKE. What role did Dr. Cooper play in development of the block grant proposal for health. Under the proposed legislation for health revenue sharing each State would receive about the same in fiscal year 1977 as in fiscal year 1976—this is if we use the administration's figures for fiscal year 1976 funding. Over a period of years, however, several States would lose large sums of money. Why is this redistribution necessary and do you personally support such a concept?

Secretary MATHEWS. While the initial idea of the block grant in this year's budget was developed outside HEW, Dr. Cooper and his staff, as well as others in the Department, worked very closely with OMB and the White House in developing the proposal's specific details. If my memory is correct Senator the $10 billion total for the health block is significantly larger than 1976. Yes, here are the numbers—$10 billion in 1977 versus $9.2 billion in 1976 based upon the President's request; and, even with the override of the President's veto of the HEW appropriations bills, the total in 1977 is greater than 1976.

Yes, under the formula, there would be a redistribution among States. What we are trying to do is to provide more equity in the distribution of Federal resources. Right now, some States are receiving a disproportionate share of the health dollars. Over time, the formula would gradually put all States on the same basis. I am in favor of this proposal.

Senator MAGNUSON. What is the mechanism and the basis for awarding indirect costs on research grants and contracts?

Mr. YOUNG. Nonprofit institutions, colleges and universities, hospitals, State and local units of government and other types of nonprofit organizations, which desire indirect cost reimbursement are required to submit indirect cost proposals to the Office of the Regional Comptroller in the HEW Regional Director's Office of the region in which they are geographically located. These proposals are reviewed by professional accountants qualified to apply and interpret cost principles issued by the General Services Administration or the Department. Negotiations are conducted and formalized by Negotiation Agreements. The Negotiation Agreements are distributed to all principal operating components of the Department and other concerned Federal agencies. The existence of a negotiation agreement is authority to the Department's principal operating components to reimburse a given institution for indirect cost at the rate stipulated in the agreement.

A similar arrangement exists for commercial organizations except that the negotiations are performed by principal operating components contracting officers and price analysts.

Senator MAGNUSON. Do other Federal agencies become involved in awarding indirect costs? If so, what is their role in making the awards?

Mr. YOUNG. A cognizant arrangement, whereby a designated Federal agency negotiates indirect cost rates on behalf of all other Federal agencies, exists for colleges and universities and State and local units of government. HEW is the cognizant agency for the preponderence of these types of organizations. It is HEW's practice to provide other Federal agencies ample opportunity to provide input to and participate in the negotiations. The decision to award (pay) indirect cost lies with each individual Federal agency and varies from agency to agency and from program to program.

Senator MAGNUSON. What steps are being taken to insure that indirect costs are held to a minimum?

Mr. YOUNG. Indirect costs are determined in accordance with prescribed Federal cost principles. There is a separate set of principles for each of the major types of grantee and contractor organizations. The cost principles for colleges and universities and for State and local governments are issued by the General Services Administration. Government-wide principles do not currently exist for nonprofit organizations and hospitals and, consequently, HEW has developed its own. HEW has proposed a series of revisions to the college and university cost principles to the General Services Administration aimed at clarifying, strengthening and expanding their coverage to include all Federal awards rather than only research—training awards. We have also recommended to, and are working with, the General Services Administration in developing a set of principles for nonprofit institutions which can be implemented governmentwide.

Training sessions have been held for Department grants management and contracting officers to provide them with a broad overview of cost policies so as to minimize duplicate recovery of cost both as direct and indirect, and to assure a greater degree of coordination between them and the regional negotiators.

Training sessions have been held for the regional negotiators to increase their awareness of the requirements and objectives of HEW and other Federal agency programs and the impact of indirect cost on those programs.

On-site reviews of the negotiation activities performed by the regional comptrollers are being conducted to assure that negotiations are performed in accordance with Department procedures and policies in a professional manner.

Senator MAGNUSON. What percentage of the indirect cost rate negotiations are currently lagging behind schedule? What is the reason for this lage in negotiations?

Mr. YOUNG. Grantees and contractors have 6 months within which to submit their proposals after the end of their fiscal year. Not infrequently extensions are requested and granted. As a result, negotiations of particular years' rates can be eight months or more behind. Additionally, the process of negotiation places emphasis on historical costs

and therfore current reimbursement rates normally lag a year behind actual incurred costs. Negotiators will address prospective rates, if requested by institutions, when reliable data is provided. It is our goal to negotiate all indirect cost proposals within 90 days of receipt. The number of institutions which require indirect cost rates annually is approximately 2,000. Our current backlog of proposals more than 90 days old is 227 of which 123 are awaiting audits. Most of the remaining backlog is awaiting information from the proposing institution pertinent to the negotiation.

Senator MAGNUSON. Is there cost sharing on indirect cost awards?

Mr. YOUNG. As a general rule, the answer is yes. Cost sharing requirements of grantees may be met from either indirect or direct costs chargeable under a given award. Some grantees meet their cost sharing requirements with indirect cost, others with direct cost, and others a combination of both.

However, the legislation for some HEW programs such as the General Research Support Program, prohibits the reimbursement of indirect cost. Legislation on other programs such as the Elementary and Secondary Education Act has the effect of limiting indirect cost. Department policy limits or prohibits the payment of indirect cost on certain specified programs such as training grants, construction grants, grants to foreign institutions, etc.

Senator MAGNUSON. From fiscal year 1971 to 1975, indirect costs awarded under grants increased by almost 17% as a percentage of total amount awarded after adjusting for inflation. How can you explain this?

Mr. YOUNG. There is no hard data to support an explanation. However, based on our contacts with grantee institutions and our general knowledge of the field, we believe there are two major reasons for the increase. The first is that grantees are sharpening their pencils and claiming legistimate costs which they did not usually claim in the past. A second reason stated by institutions is that they have been expending proportionately more funds than they had in the past in such areas as OSHA, affirmative action, protection of human subjects and animals, fair labor standards, and other regulatory Federal programs.

Senator MAGNUSON. From fiscal year 1974 to 1975, indirect costs awarded under contracts decreased by almost 17% as a percentage of total amounts awarded. How can you explain this in light of the increase under research grants?

Mr. YOUNG. It is our understanding that the 17% figure, which the Department originally provided is in error and should be approximately 7%. We cannot provide a certain explanation for the decrease. However, it may be due to a change in the mix of the non-indirect bearing costs paid for as direct cost under contracts. For example, there is indication that the amount of subcontract costs paid for under prime contracts increased in 1975. Contractor indirect costs are not applied to subcontracts, and hence, there is an appearance of less indirect cost being paid. Additionally, contract awards for construction on which indirect cost are not paid, increased $7.5 million in 1975 over 1974 tending to further reduce the aggregate effective rate.

As a general rule, the indirect cost rates used for contracts and grants at any given institution are the same.

Mr. Chairman, I have some charts and figures relating to indirect costs that I would like to submit for the record.

[The information follows:]

INDIRECT COST STATISTICS

Colleges and Universities

1. Indirect Cost Paid vs. Direct Cost Paid - Total Federal R&D Awards:

	Total[(a)]	Direct[(b)]	Indirect[(b)]	%[(b)]
1970	$1,446.6	$1,115.6	$331.0	22.9
1972	1,853.0	1,373.0	480.0	25.9
1973	1,870.5	1,316.5	554.0	29.6
1974	2,085.3	1,432.3	653.0	31.3
1975	737.9(c)	552.9(c)	185.0(c)	33.5

(a) NSF report of Federal obligations for R&D.
(b) Extrapolited using NIH research grant payment listing for years shown. NIH accounts for approximately 35% of R&D awards to colleges and universities.
(c) NIH C&U only - total Federal not yet available.

2. Effect of Inflation on Indirect Costs

	Direct Cost	Indirect Cost
Increase FY 1974 over FY 1972 before adjustment for inflation	16.1%	40.0%
after adjustment for inflation (constant 1972 dollars)	3.2%	24.3%

3. Average Component Parts of Indirect Cost Rate

	% of Pool[(a)]	% Increase[(b)]
Departmental Administration	31.5	28.3
Research Administration	6.0	47.6
General and Administration	18.3	26.9
Operation and Maintenance	26.2	41.8
Equipment Use Charges	5.1	34.3
Building Use Charges	4.9	31.7
Student Services	1.8	31.3
Library	6.2	29.2
	100.0	

(a) Source - most current indirect cost proposals of top 77 NIH grantees (for most part proposals based on FY 1974 cost experience).

(b) Increase in costs of top 77 NIH grantees as reflected by indirect cost proposals on hand. For example, if institution had 1970 and 1974 proposals on hand, difference reflects increased costs for those years. If institution had only 1972 and 1974 proposals on hand, difference reflects 3 year increase. Effect of methodology is that % increases are conservative (low).

4. Agency Share of R&D Awards to College and Universities - 1974[a]

DHEW	54.1%
NSF	18.1%
DOD	8.8% (b)
All Other	19.0%
	100.0%

(a) Mix has held relatively steady from 1972-1975.
(b) Does not include DOD/NASA/AEC GOCO type labs. Operated by colleges and universities. These are discrete, independent operations.

SUBCOMMITTEE RECESS

Senator MAGNUSON. All right, we thank you very much, and the hearings will stand in recess, subject to the call of the Chair.

(Whereupon, at 3:52 p.m., Thursday, January 29, the subcommittee was recessed, to reconvene at the call of the Chair.)

DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1977

FRIDAY, JANUARY 30, 1976

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 2 p.m. in room S–126, the Capitol, Hon. Warren G. Magnuson (chairman) presiding.

Present: Senator Magnuson.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

STATEMENT OF THEODORE COOPER, ASSISTANT SECRETARY FOR HEALTH

ACCOMPANIED BY:

DR. DAVID J. SPENCER, DIRECTOR, CENTER FOR DISEASE CONTROL
DR. DONALD S. FREDRICKSON, DIRECTOR, NATIONAL INSTITUTES OF HEALTH
DR. ROBERT VAN HOEK, ACTING ADMINISTRATOR, HEALTH SERVICES ADMINISTRATION
JAMES D. ISBISTER, ADMINISTRATOR, ALCOHOL, DRUG ABUSE AND MENTAL HEALTH ADMINISTRATION
DR. KENNETH M. ENDICOTT, ADMINISTRATOR, HEALTH RESOURCES ADMINISTRATION
CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER
PETER J. BERSANO, DIRECTOR, OFFICE OF RESOURCE MANAGEMENT, PUBLIC HEALTH SERVICE

OPENING REMARKS BY CHAIRMAN

Senator MAGNUSON. This afternoon we are pleased to have Dr. Ted Cooper, the Assistant Secretary for Health, testifying on the "health overview."

The budget request for the health programs is very low—over $700 million below the amount Congress provided in the fiscal year 1976 bill.

Budget levels are a matter of priority. Congress has placed a very high priority on the health needs of this Nation, and we are caught in a constant battle with the administration over the budget requests in this important area.

The President's budget creates many of the same problems again this year as we had last year.

You are proposing that nearly every health services program be cut back below previous levels. This includes completely wiping out comprehensive health grants to States and reducing other service and prevention programs by 27 percent or more. For medical research, the cuts are there, too—although not as big as for other health programs. There is, however, a proposal to consolidate all of the NIH programs into one budget which would cause all of the Institutes a great deal of trouble and force them to lose their visibility.

For alcohol, mental health, and health resources programs across-the-board cuts is the best way to describe the budget request.

This is a pretty bleak request. I hope Dr. Cooper will be able to present us with a good, clear picture of why such cuts are necessary and what would happen if these cuts were allowed to stand.

BIOGRAPHICAL SKETCH

Dr. Cooper, we are pleased to have you with us. We have noted those associates which are accompanying you. We will place your biographical sketch in the record at this point, after which you may proceed with your statement.

[The biographical sketch follows:]

Name: Theodore Cooper, M.D.

Position: Assistant Secretary for Health.

Birthplace and date: Trenton, N.J., December 28, 1928.

Education: B.S., Georgetown University, 1949; M.D., St. Louis University School of Medicine, 1954; Ph. D., St. Louis University, 1956.

Experience: May, 1975, Present: Assistant Secetary for Health, Department of Health, Education, and Welfare.

1974–May 1975: Deputy Assistant Secretary for Health, Department of Health, and Welfare.

1968–74: Director, National Heart and Lung Institute.

1967–68: Associate Director for Artificial Heart-Myocardial Infarction Program—National Heart Institute.

1966–68: Professor and chairman, department of pharmacology and professor of surgery, University of New Mexico School of Medicine.

1964–66: Professor of surgery, St. Louis University.

1962–64: Associate professor of surgery, St. Louis University.

1961–65: Director, Center for Cardiovascular Research, St. Louis University.

1960–62: Assistant professor of surgery, director section of surgical physiology, St. Louis University.

1959–60: Surgeon, U.S. Public Health Service, National Heart Institute.

1958–59: Assistant Resident in surgery, St. Mary's Group of Hospitals, St. Louis University.

1956–58: S.A. Surgeon, U.S. Public Health Service, National Heart Institute.

1954–55: Intern, St. Mary's Group of Hospitals, St. Louis University.

Professional organizations: American Thoracic Society, American Society for Clinical Investigation, American Physiological Society, Society for Experimental Biology and Medicine, American Society for Pharmacology and Experimental Therapeutics, International Cardiovascular Society, American College of Chest Physicians, American Society for Artificial Organs, American Federation for Clinical Research, American Society for Clinical Investigation, American Association of University Professors, American Association for Advancement of Science, American College of Cardiology, Japanese Pharmacological Society.

American Heart Association, Association of Military Surgeons, Commissioned Officers Association—USPHS, Sigma Xi, Alpha Omega Alpha, Phi Delta Epsilon.

Honors and awards: Sixteenth Honorary Lecture Award, Albany Medical College, Albany, 1972. John J. Hammond Lecture, St. John's Medical Center, St. Louis, 1972. Arthur M. Master Lecture, Mount Sinai School of Medicine, N.Y., 1972. Gold Heart Award of the American Heart Association. DHEW Superior Service Honor Award, 1972. St. Louis University Alumni Merit Award, 1972. James E. Perkins Lecture—NTRDA, Los Angeles, 1971. Southern Medical Association Lecture, Baylor College of Medicine, Houston, 1971. G. Lyman Duff Memorial Lecture—AHA Anaheim, 1971. George E. Brown Memorial Lecture—AHA, Anaheim, 1971. Research Career Development Award, USPHS, 1962–1966. Who's Who in American Colleges and Universities, 1956. Bordon Award, St. Louis University, 1954.

BUDGET REQUEST FOR OFFICE OF THE ASSISTANT SECRETARY FOR HEALTH

Dr. COOPER. Mr. Chairman and members of the committee, I am pleased to appear today in connection with the 1977 budget request for the activities of the Office of the Assistant Secretary for Health.

The 1976 Senate report contained a reduction of $2,446,000 for this activity and recommended that a portion of the positions in the account be transferred to the various health services, research, regional, and prevention programs. We have achieved a net reduction of 132 positions. The Office of the Assistant Secretary for Health eliminated 36 positions and has transferred 102 positions to the various Public Health Service agencies to be integrated directly with their program operations. In addition, 11 positions were transferred to the PHS service and supply fund so as to more accurately relate direct service functions with operational activities of the health agencies. Thirteen positions were transferred into this appropriation as a result of decentralization of personnel operations and four positions were transferred in from the General Departmental Management appropriation in support of the nationwide long-term care enforcement standards efforts.

I would like to summarize the budget request that is before you.

REGIONAL MANAGEMENT

In 1977, $5.7 million is requested to support the Public Health Service's regional management functions including the Regional Health Administrators and the headquarters staff which provides advice to the Assistant Secretary for Health in matters pertaining to coordination and management of operations in the 10 regional offices.

The regional offices activity involves decentralized health programs funded by appropriations of four of the six PHS health agencies. Currently there are 6,000 grants totaling $1.6 billion being awarded and administered in the regional offices.

PROGRAM DIRECTION AND SUPPORT SERVICES

The program direction and support services activity for which we are requesting $14.4 million, provides staff support to the Assistant Secretary for Health in carrying out his managerial responsibilities over the six health agencies and as staff advisor to the Secretary on health matters. Examples of some of the activities in this area are as follows: The Office of Program Implementation has assisted in the

resolution of health issues crossing agency lines through the Implementation Planning System for new legislation and the Operational Planning System which permits tracking or progress in our highest priority objectives. A manual has been prepared and distributed to grant applicants and guarantees which summarizes the Public Health Service's grant policies. Support is provided to the Department's medical malpractice efforts, including coordination of the research program and analysis of policy and planning issues.

The forward plan through 1981 was prepared and has effectively illuminated the difficulty of clearly articulating any set of general principles regarding the differences between the Federal role and State, local, private and voluntary roles in the health sector. In certain health programs, Federal involvement extends very deeply into specific projects at local levels, while in others it takes a subsidiary role to State and local governments or the private sector. Through the forward plan, we are examining and shaping the major dimensions of the Federal role, without seeking to impose any artificial consistency from one theme to the next.

HEALTH CARE ASSURANCE

A total of $1.5 million is required for support of the health care assurance activities in the Office of the Assistant Secretary for Health. The newly created Office of Quality Standards, as well as the offices of Nursing Home Affairs and Population Affairs provide leadership in insuring that the four determinants of health care quality: effectiveness, safety, cost, and patient satisfaction are present in a quality assurance process that merges the shared responsibilities of health professionals and government.

PRESIDENT'S COUNCIL ON PHYSICAL FITNESS AND SPORTS

We are requesting $599,000 for support of the President's Council on Physical Fitness and Sports. The American sedentary way of life constitutes a serious national health problem. Through this program, we seek to promote private support for physical fitness and amateur sports so as to more effectively integrate regular exercise into the normal day to day activities of our citizens.

SUMMARY

In summary, the budget request for the Office of the Assistant Secretary for Health is $22,216,000, an increase of $598,000 over 1976 to provide for mandatory costs. It does not reflect any increase in manpower for the Office of the Assistant Secretary for Health.

JUSTIFICATION

Mr. Chairman, at this point in the proceedings I would like to present the justification material for the Office of the Assistant Secretary for Health and ask that it be placed in the record.

[The justification follows:]

Justification

Appropriation Estimate

For expenses necessary for the Office of the Assistant Secretary for Health, [$20,842,000] *$22,216,000*.

Amounts Available for Obligation

	1976 Appropriation	1977
Appropriation	$20,842,000	$22,216,000
Proposed supplemental	666,000	---
Subtotal, adjusted appropriation	21,508,000	22,216,000
Comparative transfer from:		
"General Departmental Management" for administrative support of nationwide long-term care enforcement standards	110,000	---
Subtotal, budget authority	21,618,000	22,216,000
Total, obligations	21,618,000	22,216,000

Summary of Changes

1976 Estimated obligations	$21,618,000
1977 Estimated obligations	22,216,000
Net change	+598,000

	1976 Base Pos.	1976 Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
Built-in:				
1. Within grade increases	---	$259,000	---	$249,000
2. Annualization of October 1975 pay raise costs	---	666,000	---	223,000
3. FTS and telephone rate increases	---	152,000	---	6,000
4. Increase in postage rates	---	66,000	---	18,000
5. Standard Level User Charge	---	1,377,000	---	82,000
6. PHS Service and Supply Fund costs	---	1,101,000	---	78,000
Subtotal				656,000
Decreases:				
Built-in:				
One less day of pay				-58,000
Total, net change				598,000

Obligations by Activity

	1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Regional Management..	160	$5,197,000	160	$5,266,000	---	+$69,000
Program Direction and Support Services...	414	12,958,000	414	13,371,000	---	+413,000
Health Care Assurance	47	1,495,000	47	1,521,000	---	+26,000
President's Council on Physical Fitness and Sports.....	12	591,000	12	599,000	---	+8,000
Standard Level User Charge.....	---	1,377,000	---	1,459,000	---	+82,000
Total obligations.	633	21,618,000	633	22,216,000	---	+598,000

Obligations by Object

	1976 Appropriation	1977 Estimate	Increase or Decrease
Total number of permanent positions....	633	633	---
Full-time equivalent of all other positions.....	57	57	---
Average number of all employees.....	671	671	---
Personnel compensation:			
Permanent positions.....	$13,680,000	$14,022,000	+$342,000
Positions other than permanent.....	867,000	877,000	+10,000
Other personnel compensation.....	208,000	210,000	+2,000
Subtotal, personnel compensation	14,755,000	15,109,000	+354,000
Personnel benefits.....	1,588,000	1,622,000	+34,000
Travel and transportation of persons.	971,000	971,000	---
Transportation of things.....	30,000	30,000	---
Rent, communications, and utilities..	2,045,000	2,151,000	+106,000
Printing and reproduction.....	185,000	185,000	---
Other services.....	1,776,000	1,880,000	+104,000
Supplies and materials.....	169,000	169,000	---
Equipment.....	99,000	99,000	---
Total obligations by object.....	21,618,000	22,216,000	+598,000

Significant Items in House and Senate Appropriations Committee Reports

Item	Action taken or to be taken
1976 Senate Report	
Assistant Secretary for Health	
The Committee reduced the budget request by $2,446,000 and recommended that a portion of the positions in this account be transferred to the various health services, research, regional and preventive programs (page 77).	To achieve this objective, the Office of the Assistant Secretary for Health eliminated 36 positions and transferred an additional 102 positions to be integrated directly with program operations in the various PHS agencies. The transfer of these 102 positions necessitates that the program activities receiving these positions absorb the costs of the staff within their appropriation and will in some cases require the reprogramming of program funds in order to support these transfers.

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1967...	$8,207,000	$8,069,000	$7,648,000	$7,858,000
1968...	9,087,000	8,358,000	8,358,000	8,358,000
1969...	9,073,000	9,073,000	9,073,000	9,073,000
1970...	9,898,000	9,898,000	9,898,000	9,898,000
1971...	12,636,000	12,636,000	12,636,000	12,636,000
1972...	12,497,000	12,497,000	12,497,000	12,497,000
1973...	20,519,000	20,519,000	20,519,000	20,519,000
1974...	22,658,000	22,658,000	15,354,000	20,354,000
1975...	23,209,000	23,089,000	22,025,000	22,025,000
1976...	23,288,000	23,142,000	20,842,000	20,842,000*
1977...	22,216,000			

* Conference agreement.

Assistant Secretary for Health

	1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Activities						
1. Regional Management..	160	$5,633,000	160	$5,728,000	---	+$95,000
2. Program Direction and Support Services...	414	13,899,000	414	14,368,000	---	+469,000
3. Health Care Assurance	47	1,495,000	47	1,521,000	---	+26,000
4. President's Council on Physical Fitness and Sports.....	12	591,000	12	599,000	---	+8,000
Total.....	633	21,618,000	633	22,216,000	---	+598,000

General Statement

This appropriation provides support for the administrative staff required to administer the PHS health programs in the regional offices, staff for the Assistant Secretary for Health, staff for the coordination of the overall National efforts to assure the quality of the development of health care standards and resources necessary for the continuation of the National physical fitness and sports program. The Assistant Secretary for Health is the principal advisor to the Secretary on health policy and health-related activities for the Department, and is responsible for the direction of the Public Health Service agencies. He provides leadership and policy guidance for health and health-related activities for the people of the Nation, and for maintaining relationships with other governmental agencies, private agencies, and some international organizations concerned with health-related matters.

During 1976, due to congressional reductions from the budget request, the Office of the Assistant Secretary for Health eliminated 36 budgeted positions and transferred an additional 102 positions to the Public Health Service agencies. In addition, 11 positions were transferred from this account to the PHS Service and Supply Fund so as to more accurately relate direct service functions with operational activities of the various health agencies. Thirteen positions were transferred into this appropriation from the PHS Service and Supply Fund as a result of decentralization of personnel operations and 4 positions were transferred from the General Departmental Management appropriation in support of the nationwide long-term care enforcement standards efforts.

Regional Management

1976 Appropriation		1977 Estimate		Increase or Decrease	
Pos.	Amount	Pos.	Amount	Pos.	Amount
160	$5,633,000	160	$5,728,000	---	+$95,000

The staff supported by this activity is located in the ten PHS regional offices and in the PHS Office of Regional Operations. The regional staff supports the immediate office of the Regional Health Administrators, the principal Federal health representatives in the regions, who are responsible to the Assistant Secretary for Health. The staff of the Office of Regional Operations, located in headquarters, acts as an advisor to the Assistant Secretary for Health on matters pertaining to the operation of the PHS regional offices. The regional offices activity involves an estimated 40 decentralized health programs funded by appropriations of four of the six PHS health agencies. Currently there are approximately 6,000 grants totaling $1.4 billion being awarded and administered in the regional offices.

During 1976, due to congressional reductions from the budget request, the grants management function consisting of 61 positions was transferred to three of the health agencies directly involved with the operations of the grants program and 9 additional positions were eliminated.

In 1976, the Regional Management staff continued to provide the overall management capabilities necessary for the administration of health programs in the ten regional offices. The main emphasis was on improving the Regional Health Administrator's Work Program system so as to more effectively carry out operational responsibilities in the regions. In addition, strong emphasis continued to be placed on improving coordination between the regional offices and State and local health agencies, improving management support activities, providing technical assistance in the area of grants and contracts administration and in implementing a manpower management program to cover 100% of regional activities.

In 1977, the regional offices will implement expected recommendations of the Management Information Systems task force to improve flow of management information within the regional offices and initiate steps to validate data in the regional Manpower Management program.

A net increase of $95,000 is required to provide for mandatory costs as follows:

1. Within grade increases effective during the year	+$34,000
2. Annualization of the October 1975 pay raise	+49,000
3. Standard Level User Charges	+26,000
4. One less day of pay	-14,000
Total net change	+95,000

Program Direction and Support Services

1976 Appropriation		1977 Estimate		Increase or Decrease	
Pos.	Amount	Pos.	Amount	Pos.	Amount
414	$13,899,000	414	$14,368,000	---	+$469,000

This activity provides staff support for the Assistant Secretary for Health for guidance, leadership, and direction to the Public Health Service agencies on all health and health-related activities, including research and development; education and training; organization, financing and delivery of health care services; provision of preventive health services; and protection to the public from unsafe foods, drugs, and medical devices.

During 1976, due to congressional reductions from the budget request, 17 positions were transferred from this activity to the Public Health Service agencies and 24 positions were eliminated. Additionally, 11 positions were transferred to the PHS Service and Supply Fund in an effort to more accurately relate direct service functions to operational activities of the health agencies. As a result of the decentralization of personnel operations, 13 positions were transferred into this activity from the PHS Service and Supply Fund.

This activity includes staff and related costs for the Immediate Office of the Assistant Secretary for Health, and the Offices of Equal Employment Opportunity, Public Affairs, Health Legislation, Program Implementation, International Health, Administrative Management, and Policy Development and Planning.

The program implementation function proved effective in development and implementation of health planning legislation, administering the National Environmental Policy Act to improve coordination of programs involving toxic substances, directing committee management functions, coordinating patent appeals, and assisting in the resolution of health issues crossing agency lines. This function will continue in 1977 to aid the implementation, regulation and management of existing and new program policies. In addition, a manual will be developed and issued to assist in the management and control of the Public Health Service's over 270 scientific and technical committees.

During 1976, technical assistance on international health matters was rendered to the Department of State, the Agency for International Development, the World Health Organization, the Pan American Health Organization, numerous international health and health-related organizations, Ministries of Health of many countries, and domestic organizations and individuals seeking advice on international health matters. Major accomplishments were made in the

strengthening of domestic health programs by making use of knowledge provided by international health organizations and foreign Ministries of Health, as well as knowledge gained through development of programs overseas as pilots for health programs in this country. New initiatives will involve the evaluation of ongoing bilateral programs so that decisions can be made to maintain or expand those of mutual benefit to the United States and other countries and to reduce or eliminate those which appear to be of limited value.

In the area of grants administration, a PHS grants policy manual was issued for use by applicant and grantee organizations which summarizes all PHS grant policies. An audit management system was developed to insure that all audit issues are promptly resolved and that the recommendations cited are effectively implemented. A plan was developed to assure competency at the regional office level to conduct self-evaluation of personnel management functions and to promote expanded participation of regional personnel officers in management's decision-making process involving human resources. Leadership was provided to the implementation and maintenance of a PHS-wide manpower management program.

The Forward Plan through 1981 was prepared coordinating health strategies in the areas of health data, health care, health improvement, health research, health protection, and health care financing. Other accomplishments included staff support to the medical malpractice effort and coordination of programs and policies which address the issues of resources, productivity and credentialing of health personnel, and health planning. These efforts will be continued in 1977 with particular emphasis on coordinating research plans for experiments and demonstrations related to changes in reimbursement methods and benefit changes aimed at reducing the cost of health care without adversely affecting the quality of care provided under the Social Security Act and completing the analyses of long-term care and ambulatory surgery projects.

In summary, a total of $14,368,000 is requested for the continuation of this activity at the 1976 level. The net increase of $469,000 over the 1976 operating level of $13,899,000 represents mandatory costs as follows:

1.	Within grade increases	+$195,000
2.	Annualization of the October 1975 pay raise	+156,000
3.	Standard Level User Charge	+56,000
4.	Payments to PHS Service and Supply Fund	+78,000
5.	FTS and telephone rate increases	+6,000
6.	Increase in postage rates	+18,000
7.	Less one day of pay	-40,000
	Total net change	+469,000

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Health Care Assurance

1976 Appropriation		1977 Estimate		Increase or Decrease	
Pos.	Amount	Pos.	Amount	Pos.	Amount
47	$1,495,000	47	$1,521,000	---	+$26,000

The staff supported by this activity provides technical advice on programs of health care standards and quality assurance matters as well as a range of other matters pertaining to quality standards.

During 1976, 24 positions were transferred to the health agencies and 3 eliminated due to congressional reductions from the budget request. Four positions were transferred from the General Departmental Management appropriation in support of the nationwide long-term care enforcement standards effort.

This activity includes staff and related costs for the Offices of Quality Standards, Nursing Home Affairs, and Population Affairs.

Some of the achievements and objectives for 1976 and 1977 are:

The newly created Office of Quality Standards will coordinate for the Assistant Secretary activities regarding Professional Standards Review Organizations, Utilization Review, quality assurance aspects of the Health Maintenance Organizations, and the End-Stage Renal Disease programs.

The Office of Nursing Home Affairs, as an outgrowth of the Long-Term Care Study, will disseminate in 1976 publications on assessing health care needs in skilled nursing facilities, physicians' drug prescribing patterns, and a consumers' guide on selecting a nursing home. Also published was the Introductory Report of the Long-Term Care Facilities Improvement Campaign. In 1976, trial development of tools to objectively measure the quality of nursing homes will be completed, leading to establishment in 1977 of criteria to ensure uniform national inspection and rating of nursing homes.

In 1976, the Office of Population Affairs worked toward the resolution of issues related to informed consent for sterilization, especially those related to individuals who by reason of age or other factors are not considered competent to provide informed consent. Work continued with the Bureau of Community Health Services/PHS, and the Social and Rehabilitation Service regarding the effects of new

social service legislation as it related to family planning services under Title XX of the Social Security Act. In 1977, the Office of Population Affairs will continue its regular program of staff assistance to the Assistant Secretary for Health and the Secretary and its program direction activities with the Bureau of Community Health Service and the Center for Population Research. Staff studies related to national health insurance will be an area of emphasis.

In summary, a total of $1,521,000 is required for the continuation of this activity. The net increase of $26,000 over the 1976 operating level of $1,495,000 represents mandatory costs as follows:

1. Within grade increases	+$16,000
2. Annualization of the October 1975 pay raise	+14,000
3. Less one day of pay	-4,000
Total net increase	+26,000

President's Council on Physical Fitness and Sports

1976 Appropriation		1977 Estimate		Increase or Decrease	
Pos.	Amount	Pos.	Amount	Pos.	Amount
12	$591,000	12	$599,000	---	+$8,000

This activity supports staff and related costs for the continuation and furtherance of the National Physical Fitness and Sports Program; places major emphasis in the areas of promoting private support for physical fitness and mass amateur sports development; conducts continuing public service information programs about the nature and extent of the Nation's physical fitness problem; provides technical service to Federal, State and local agencies, and education, recreation, and sports and physical fitness associations; conducts a number of National incentive programs; and sponsors regional and State inservice training clinics for physicians, physical educators and other professionals.

During 1976 the Council's motivational and incentive programs for youth, adults, and physical education leaders were expanded. Leadership training was provided through: (1) regional clinics on physical fitness and sports for over 10,000 physical fitness and physical education leaders; (2) workshops on physical fitness for the elderly for over 1,600 participants; and (3) medical symposiums on exercise and health for 1,500 physicians and physical educators. A Fire Fighter's Fitness program with resource materials and films was developed and implemented for fire fighters. A followup on the 1972 National Adult Fitness survey updated the status of exercise and physical activity habits of adults. The number of governors' councils on physical fitness increased. Evaluation of the National Youth Physical Fitness test was completed and new norms developed. The private sector continued to support a number of physical fitness programs developed by the Council.

Plans for 1977 will involve: (1) a special effort to enlist the active support and assistance of city officials in developing and implementing mass physical fitness programs in community recreation departments; (2) assisting business, industry, government, and labor organizations in the establishment of sound physical fitness programs designed to elevate employees' health and reduce health-care costs resulting from physical inactivity; and (3) conducting educational programs for the general public on the importance of exercise and the value of regular physical activity for improved health. In addition, the

Council's award program will be expanded to include a Master of Fitness Award for adults.

A mandatory increase of $8,000 is requested to provide for within grade costs, $4,000; and annualization of the October 1975 pay raise, $4,000.

Program Purpose and Accomplishments

Activity: Regional Management

1976		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
160	$5,633,000	Indefinite	160	$5,728,000

Purpose: This activity supports the immediate office of the Regional Health Administrators and a core headquarters regional advisory staff to the Assistant Secretary for Health. The Regional Health Administrators are the principal regional health officials responsible to the Assistant Secretary for Health for determining and implementing health policies, priorities, goals, and objectives within the scope of national health policies.

Explanation: To provide funding for advisory, administrative and managerial support in the implementation of decentralized health programs funded by appropriations from four of the six health agencies.

Accomplishments in 1976: In 1976, the emphasis was on improving the Regional Health Administrator's Work Program system so that the regional offices would be in a position to more effectively carry out operational responsibilities in the regions. Analysis was made of the flow of management information in the regional offices.

Objectives in 1977: The regional offices will implement recommendations of the Management Information Systems task force to improve the flow of management information within the regional offices and initiate steps to validate data in the regional Manpower Management program.

Activity: Program Direction and Support Services

1976		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
414	$13,899,000	Indefinite	414	$14,368,000

Purpose: This activity provides staff support for the Assistant Secretary for Health for guidance, leadership, and direction to Public Health Service programs on all health and health-related activities, including research and development, education and training, organization, financing and delivery of health care services, preventive health care, and problems relating to unsafe foods and drugs.

Explanation: To provide funding for program direction and support services for the Assistant Secretary for Health.

Accomplishments in 1976: In 1976, the Forward Plan for Health was prepared and accomplishments were made in the development of comprehensive health insurance proposals and other health policies and needs. Major gains continued to be made in the integration of the Public Health Service's international activities and domestic programs as well as the coordination of policy and health functions among the health agencies.

Objectives for 1977: Management control of scientific and technical committees will be improved. More domestic benefit will be derived from bilateral health programs.

Activity: Health Care Assurance

1976		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
47	$1,495,000	Indefinite	47	$1,521,000

Purpose: The staff supported by this activity is responsible for the development of National policies and procedures for quality assurance and health care standards.

Explanation: To provide funding for staff and related costs for Quality Standards, Nursing Home Affairs, and Population Affairs.

Accomplishments in 1976: Leadership was provided in establishing means for the identification of uniform data requirements of the Professional Standards Review Organizations (PSRO) programs and the design of PSRO data. Program funding plans and evaluation and research efforts were accomplished in order to carry out the PSRO program objectives. Uniform inspections and ratings for nursing homes were developed and tested for grading nursing home care. Some 4 million women received subsidized family planning services through organized programs.

Objectives in 1977: There will be continued efforts to improve nursing home care and facilities along with making home health a viable alternative to the spiraling health care costs. National health insurance's impact on delivery of family planning services will be assessed.

Activity: President's Council on Physical Fitness and Sports

1976		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
12	$591,000	Indefinite	12	$599,000

Purpose: This activity supports a national program of encouraging greater emphasis in the areas of physical fitness and sports.

Explanation: To provide funding for the President's Council on Physical Fitness and Sports and the supporting staff.

Accomplishments in 1976: In 1976, the Presidential awards program was expanded; the number of governors' councils on physical fitness increased; regional clinics, workshops, and symposiums were held with physicians, physical educators, and the elderly; and a fire fighters fitness program was developed and implemented.

Objectives for 1977: Special efforts will be exerted to assist public and private agencies and organizations in developing and implementing physical fitness programs as a basis for the improvement of health which will result in a reduction in financial costs and an increase in the quality of human life.

Transition Quarter Analysis

	Budget Authority by Activity	
	1976 Estimate	Transition Quarter
1. Regional Management.....	$5,197,000	$1,316,000
Standard Level User Charge.....	436,000	109,000
2. Program Direction and Support Services.....	12,958,000	3,299,000
Standard Level User Charge....	941,000	235,000
3. Health Care Assurance.....	1,495,000	377,000
4. President's Council on Physical Fitness and Sports.....	591,000	149,000
Total.....	21,618,000	5,485,000

Explanation

Funds are required for the transition quarter to permit continuation of the 1976 operating level during this interim period.

BUDGET REQUEST FOR PUBLIC HEALTH SERVICE

Dr. COOPER. I would now like to present the fiscal year 1977 budget request for the Public Health Service and to outline some of the goals and objectives we hope to achieve within the framework of this budget. Before discussing specific budget proposals, however, I would like to place the requests you have before in perspective by describing the state of the Nation's health.

HEALTH STATUS

The health of the American people is, without a doubt, one of our most important national resources. Without good health, our citizens can do little to achieve other goals—for themselves, their children, or for the Nation as a whole. We have made great strides in recent years in improving our health status. Yet this progress is sometimes obscured when we view it on a year-to-year basis only. Earlier this month, we transmitted to the Congress a three volume, 600-page study entitled, "Health, United States, 1975." The report, the first in an annual series, details the tremendous progress we have made in improving the health of the Nation, yet outlines the enormous challenge that still remains.

INFANT MORTALITY

Infant mortality, often regarded as a major indicator of a Nation's well-being, declined from 29.2 deaths per 1,000 live births in 1950 to an estimated 16.5 deaths in 1974. Despite the achievement of reducing infant mortality in the United States by 40 percent since 1950, we as a Nation still rank 15th in this statistic. In addition, the infant death rate for nonwhites continued to run considerably higher than for whites.

Early prenatal care is essential for detecting conditions which may lead to complications of pregnancy and delivery as well as fostering conditions for healthy natal development. While about 70 percent of all pregnant women start prenatal care during the first 3 months of pregnancy, only 52 percent of nonwhite women undertake such care at that time. If we are to continue to reduce our infant mortality rate, it will be necessary to focus even more attention on the need for prenatal care.

LIFE EXPECTANCY

Life expectancy, another key indicator of the Nation's health, is now 76.7 years for white women and 68.9 years for white men, an increase of 2.1 years and 1.2 years, respectively, in the past decade. But life expectancy for nonwhites continues to lag, with a life span of about 71.3 years for women and 62.9 years for men. Despite the decline in death rates from heart conditions in recent years, heart disease remains the leading cause of death in this country. Heart conditions are also the leading cause of inpatient hospitalization and cause more long-term limitation of activity than any other disease.

DEATH RATES FROM MAJOR DISEASES

During the past 25 years, death rates from some other major diseases have declined. The rates for strokes, arteriosclerosis, and kidney dis-

ease have all shown marked reductions. However, a notable exception has been cancer, which ranks second in causes of death and has increased from 269 deaths per 100,000 persons in 1950 to 292 in 1973. Other exceptions to the general decline in mortality rates are the increases in rates for the fifth leading cause of death of the middle-aged, cirrhosis of the liver, and for the ninth cause, respiratory diseases. Death rates for cirrhosis of the liver, which is associated with alcoholism, and respiratory diseases, which are aggravated by smoking and air pollution, still cause only a small fraction of the number of deaths caused by heart disease.

While the leading causes of death are indicative of major health problems and of losses to the economy because of death during the working years, mortality data alone fail to describe the full impact of disease and disability. Interview data reveal that of the 43 million people who are 45 to 64 years old, 1.5 million are limited in their activities because of heart problems. Approximately 1.3 million are limited by arthritis, 620,000 by impairments of the lower limbs or hips, 420,000 by hypertension and 400,000 by diabetes. In total, there are 8 million adults in their middle years who report some degree of chronic limitation of activity.

VENEREAL DISEASE

One disturbing statistic is that a preventable condition, venereal disease, is reaching epidemic levels. When undetected cases and underreporting are considered, it is estimated that about 2.7 million cases of gonorrhea occur each year. There are about 81,000 new cases of infectious syphilis each year and about 450,000 persons are in need of treatment for syphilis at the present time.

HEALTH CARE FOR ALL ECONOMIC LEVELS

Although there are still wide differences in health status between poor and not-so-poor, it is evident that the gap in opportunity for health care has been reduced. In 1974, 17 percent of the poor had not seen a physician within 2 years, in contrast with 23 percent in 1964. For those who were not poor, the respective proportions were 13 and 18 percent. The fact that the poor often have higher rates of utilization of physician services than the nonpoor reflects both a greater need for health care in this group and the catching up of a deficit which has accumulated in earlier years.

ELDERLY POPULATION INCREASES

A dramatic change that has been occurring in our population has been the sharp rise in the number of people over 65. Between 1940 and 1970, the Nation's elderly population has doubled to 20.2 million. As a consequence, the incidence of chronic arthritis, diabetes, and other diseases linked with aging has also increased. As needs for care become overwhelming and there is no one in the household to provide this care, some solution must be found. One possibility is home health care; the other is long-term institutionalizations.

About 1 million people, 5 percent of our elderly population, reside in nursing homes and because of longer survival, 72 percent of these

are women. Nearly all of the residents have multiple chronic conditions, averaging three per person.

NATIONAL HEALTH EXPENDITURES

Health care has been taking an increasing share of the Nation's total production of goods and services. In 1975 national health expenditures totaled approximately $118.5 billion or 8.3 percent of the gross national product. This represents a per capita expenditure of $547. In 1950 these expenditures were $12 billion, representing 4.6 percent of the GNP and a per capita cost of $78. The change is due primarily to inflation and to increased use of services, including new and costly techniques of care. Sources of payment of these health care costs have shifted markedly. In 1950 over two-thirds of personal health care costs were paid directly by the patient; in 1974 the patient's direct share was one-third of the total. This shift is due to the growth in private health insurance coverage of the population and to the introduction of public programs such as medicare.

IMPACT OF INDIVIDUAL LIFESTYLES

These statistics show the progress that has been made over the years in preventing disease and delaying death as well as revealing those areas where improvement is required. While we can continue to look forward to improved medical care, it is becoming clear that a substantial improvement in health status could be achieved by individuals changing the way they live. Most accidental deaths and disabilities are preventable. So is the aggravation of health conditions due to the excessive use of alcohol and tobacco and lack of exercise and proper diet. Almost half of the adult population 22 years-of-age and older does not engage in routine physical exercise. While the proportion of adult males who smoke cigarettes dropped significantly between 1955 and 1970, from 54 percent to 43 percent, the proportion of female cigarette smokers increased from 27 percent to 31 percent during the same period. Frequent heavy drinking of alcohol is highly related to mortality; for example, males who drink heavily at least four times a week have death rates four times higher than do other drinkers. These trends and factors, which are tied to our lifestyle and the relative affluence of our society, can all be adjusted by individual action. Simply stated, the health of the people of our country can be improved if individuals would cut down on drinking and smoking, would exercise more, and eat a proper diet.

PUBLIC HEALTH SERVICE OVERVIEW

The total budget request for the Public Health Service programs presented to this committee is $1.38 billion for 1977, an increase of $180 million over the 1976 revised President's budget. As you know, there are two major legislative proposals to be submitted by the President in the coming months which will have a significant bearing upon this request. One is a proposal to consolidate 16 Federal health programs, including medicaid, into a single $10 billion bloc grant to the States. The other is to seek approval to transfer to community use or close the eight Public Health Service Hospitals. If the Congress approves

this proposal, the primary beneficiaries of these hospitals would continue to receive care from the existing PHS clinics and through contractual arrangements with community medical facilities. The budget being presented to you now, however, requests funds for these programs under existing legislative authorities to assure continuity of activities pending congressional action.

Our budget request, while recognizing resource constraints, reflects priority needs designed to prevent illness, assure access to appropriate care, contain health costs, and carry on health research. I would now like to review briefly the major items in this request.

PREVENTION

For the Center for Disease Control we are requesting $5 million increases for both the National Institute of Occupational Safety and Health (NIOSH) and for laboratory improvement. The increase will permit NIOSH to carry out increased research on hazardous substances and harmful physical agents and allow intensified efforts to identify and prevent cancer of occupational origin through field studies and epidemiological investigations in 40 high risk industries. The budget will enable DHEW to recommend to the Department of Labor during each of the next 2 years criteria on 24 hazardous substances that impinge on the health of 1.7 million in the workplace. The $5 million increase for laboratory improvement will permit a 50-percent increase in efforts to improve the ability of clinical laboratories to perform reliable and accurate tests. This will result in a savings of both dollars and unnecessary hospitalization. We will also continue our emphasis on health education so that individuals can make better informed health decisions and take action to improve their health status.

ASSURING ACCESS TO CARE

Improvements in access to appropriate care will be made through our efforts to build a rational resource allocation system. An important part of this effort to build capacity through appropriate resource allocation is the health planning program for which we are requesting $90 million in fiscal year 1977. This request will permit the orderly development of a nationwide network of 211 conditionally operational health systems agencies and 56 State health agencies.

The need to begin resolving the geographic and specialty distribution problems of qualified health professionals is another vital ingredient in assuring access to appropriate care. Our budget request of $319 million for health manpower programs is allocated in accordance with the administration's Health Professions Education Amendments of 1975 recently submitted to the Congress.

A major component of assuring access to care is our effort to build capacity directly in medically underserved areas. Within the $319 million noted, we have requested $35 million for the health service scholarship program which will support 4,650 students who agree to serve in these shortage areas. A significant increase is also being requested for the National Health Service Corps, whose mission it is to actually place health professionals in medically underserved areas.

For fiscal year 1977, $24.5 million is being requested to support 676 assignees at 330 sites. There are increases of 125 field assignees and 60 sites.

While discussing the issue of access to proper health care, it is appropriate to mention developments regarding St. Elizabeths Hospital (SEH). The accreditation for St. Elizabeths was withdrawn because of nonconformity with fire and other safety regulations, an insufficient number of qualified personnel, and the lack of adequate physical resources to meet patient needs. The President's revised budget for 1976 and the 1977 request includes resources to provide additional staff, to correct fire ant safety hazards, and to develop plans for additional space to relieve overcrowding. While the budget request assumes Federal control of the hospital for the present, we are currently working with the government of the District of Columbia to arrive at mutually agreeable terms and a date for transfer of the hospital to the District. When agreement is reached, transfer legislation and an appropriation request of $75 million for new construction and renovation will be submitted to the Congress for its approval.

COST CONTAINMENT

Access to adequate sources of health care involves removing a major barrier to care—excessive cost. The professional standards review organizations (PSRO) program is aimed at assuring high-quality care while reducing its cost. The 1977 budget level of $62 million, which reflects the impact of the recently enacted amendments to the Social Security Act, will provide for the development of PSRO's in all 203 areas nationwide. Of these, approximately 120 will actually be performing reviews of hospital admissions in fiscal year 1977. We estimate that 3 million admissions of medicare and medicaid patients will be reviewed in 1977.

Also contributing to cost containment are the efforts of the National Center for Health Statistics, which maintains a reliable, general purpose statistical data collection system. The information provided by the Center serves as an important data base for measuring the growth of health care costs as well as for supplying vital statistical data for proper health planning.

RESEARCH

Health research into the cause of disease remains a most essential element in the improvement of health status. Because of continued emphasis on the Federal role in biomedical research, a budget of $2.2 billion is proposed for the National Institutes of Health (NIH). The NIH request proposes to increase research in the emerging areas of immunology, aging, and environmental health. Other increases will provide for expanded heart and lung research and basic research on the cellular and molecular basis of disease and will permit the first phase of construction of an ambulatory care facility, which is designed to provide a more economical and effective means of evaluating the benefits of NIH research findings. In addition to biomedical research, we are also requesting funds for behavioral research in the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) and for health services research in the Health Resources Administration.

ADAMHA research provides investigation in the vital areas of mental health, drug abuse, and alcohol, while health services research has as its primary purpose improving the way health services are organized, delivered, and financed.

BUDGET REQUEST FOR "SCIENTIFIC OVERSEAS" (SPECIAL FOREIGN CURRENCY PROGRAM)

At this point in my presentation, Mr. Chairman, I would like to make a brief statement giving the fiscal year 1977 budget request for the Scientific Activities Overseas appropriation.

The Scientific Activities Overseas appropriation funds selected projects in foreign countries based on reviews for scientific merit and relevance to domestic responsibilities and objectives. Individual projects are selected by the health agencies with overall administrative responsibilities residing with the Office of International Health in the Office of the Assistant Secretary for Health.

All expenditures from this appropriation are made from U.S.-owned excess foreign currencies. These currencies, which were acquired by the United States through the sale of surplus agricultural commodities to other countries under Public Law 83-480, the agricultural Trade Development and Assistance Act, the repayment of mutual security loans, and other transactions, must be spent in the country of origin. The Treasury Department has advised us that foreign currencies will be available for use under this program in seven countries during 1977—Burma, Egypt, Guinea, India, Pakistan, Poland, and Tunisia.

We have not requested new budget authority for this program since 1974, because we did not use all of the funds which were appropriated for use in previous years. This was due to the diminishing supply of currency in certain countries, notably Israel and Yugoslavia, and political relations with others, such as Egypt and India. As a result, we could not undertake a sizable number of projects which had been planned or developed.

During the past year, however, there has been a significant change in program potential in Egypt and India. A United States-Egypt Joint Working Group on Medical Cooperation, for which HEW has lead responsibility for the United States, was established. In India, a science and technology subcommittee was established under an overall United States-India Joint Cooperation Commission. These groups have added new impetus and vigor to our cooperative efforts with those two countries and we now expect an expansion of the program. Accordingly, we are requesting $1.5 million in new budget authority in 1977, which when added to the prior years unused funds will provide a total program level of $13,807,000.

Examples of studies presently being supported under this program are pneumoconiosis due to mica dust inhalation in the mica processing industry, the role of arthropods in the transmission of leprosy, screening of indigenous herbal drugs for anticancer activity, delayed effects of X-irradiation, the epidemiology of staphylococcal diseases, chest diseases in coal miners, epidemiology and control of trachoma, zinc nutrition and other nutritional deficiencies, population dynamics and improvement of vital registration, and health services research.

JUSTIFICATION

Mr. Chairman, I ask that the justification material for the scientific activities overseas (special foreign currency program) be placed in the record at this point.

[The justification follows:]

Justification

Appropriation Estimate

SCIENTIFIC ACTIVITIES OVERSEAS (SPECIAL FOREIGN CURRENCY PROGRAM)

For payments in foreign currencies which the Treasury Department determines to be excess to the normal requirements of the United States, for necessary expenses for conducting scientific activities overseas, as authorized by law, $1,800,000 to remain available until expended: Provided, That this appropriation shall be available in addition to other appropriations for such activities, for payments in the foregoing currencies.

Amounts Available for Obligation

	1976 Estimate	1977 Estimate
Appropriation	---	$1,500,000
Unobligated balance, start of period	$27,443,000	12,307,000*
Unobligated balance, end of period	-14,319,000*	---
Total, obligations	13,124,000	13,807,000

*The difference of $2,012,000 between the unobligated balance at the end of 1976 and the unobligated balance at the start of 1977 represents estimated obligations for the transition quarter.

Summary of Changes

1976 Estimated Obligations	$13,124,000
1977 Estimated Obligations	13,807,000
Net change	+683,000

	Base	Change from Base
Program Increases:		
1. Disease Prevention Research	$3,125,000	+$246,000
2. Health Services Research	1,011,000	+142,000
3. Biomedical Research and Health Science Communication	3,808,000	+646,000
Total, increases		+1,034,000
Program Decreases:		
1. Alcohol, Drug Abuse and Mental Health Research	825,000	-88,000
2. Food and Drug Research	1,280,000	-208,000
3. Health Resources Research	3,075,000	-55,000
Total, decreases		-351,000
Total, net change		+683,000

Explanation of Changes

The $683,000 increase is the net change resulting from changes in program emphasis on specific health problems and the anticipated increase in the program in India and Poland.

Program Increase:

1. Center for Disease Control - The net increase of $246,000 will be directed toward studies to prevent and control infectious diseases

2. Health Services Administration - The net increase of $142,000 will be directed toward a program for studies aimed at improving delivery of rural health services.

3. National Institutes of Health - The net increase of $646,000 will permit a program increase of $543,000 for basic biomedical research, $53,000 for population and family planning studies and $50,000 for nutrition research.

Program Decreases:

1. Alcohol, Drug Abuse and Mental Health Administration - The decrease of $88,000 represents a decrease in a number of projects funded in F.Y. 1977 in the field of alcoholism.

2. Food and Drug Administration - The net decrease of $208,000 represents the reduction in planned drug research.

3. Health Resources Administration - The net decrease of $55,000 represents a reduction in new obligations for studies directed toward improving the organization and delivery of health services.

Obligations by Activity

Page Ref.		1976 Estimate	1977 Estimate	Increase or Decrease
238	Foreign health research	$13,124,000	$13,807,000	+$683,000

Obligations by Object

	1976 Estimate	1977 Estimate	Increase or Decrease
Travel and transportation of persons	$196,000	$210,000	+$14,000
Other services:			
Project contracts	12,928,000	13,597,000	+669,000
Total obligations	13,124,000	13,807,000	+$683,000

Authorizing Legislation

Legislation	Amount Authorized	1977 Budget Request
Agricultural Trade Development and Assistance Act of 1954, as amended, Section 104(b)	Indefinite	None
International Health Research Act of 1960, Section 3	Indefinite	$1,500,000

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1967	$19,217,000	$19,217,000	$10,000,000	$10,000,000
1968	18,685,000	15,000,000	15,000,000	15,000,000
1969	30,000,000	15,000,000	15,000,000	15,000,000
1970	3,455,000	3,455,000	3,455,000	3,455,000
1971	32,444,000	32,444,000	32,444,000	32,444,000
1972	25,545,000	25,545,000	25,545,000	25,545,000
1973	25,619,000	25,619,000	25,619,000	25,619,000
1974	1,912,000	1,912,000	1,912,000	1,912,000
1975	---	---	---	--- *
1976	---	---	---	--- *
1977	1,500,000			

*No new budget authority was requested in 1975 and 1976 due to the availability of prior years unobligated appropriation balances.

	1976 Base	1977 Estimate	Increase or Decrease
Foreign Health Research....	$13,124,000	$13,807,000	+$683,000

General Statement

The Scientific Activities Overseas (Special Foreign Currency Program) is carried out under the authorities provided by Section 104(b) of Public Law 83-480, the Agricultural Trade Development and Assistance Act of 1954, as amended; and, Section 3 of Public Law 86-610, the International Health Research Act of 1960, as amended. Funding under this appropriation is entirely with U.S.-owned "excess" foreign currencies which were generated through the sale of surplus U.S. agricultural commodities and repayments on Mutual Security Loans. In 1977, it is anticipated that currencies will be available for use by the health agencies in the Arab Republic of Egypt, Burma, Guinea, India, Pakistan, Poland and Tunisia. These "excess currency" countries are designated by the U.S. Treasury Department using the criteria that the supply of U.S.-owned currency in the country must be sufficient to finance normal U.S. needs for at least two years.

Responsibility for the overall management and coordination of the Program is vested in the Office of International Health, a staff office to the Assistant Secretary for Health. The money made available through this appropriation is used by the six health agencies to finance cooperative health research projects, training, symposiums and conferences, translations of health science literature, and related activities in the participating foreign countries.

Since the Program's inception in 1962, more than 400 research projects and related activities have been funded in eleven countries. All of the research projects are collaborative in nature and are designed to benefit the United States as well as the host country. Projects are reviewed by the government of the foreign country as well as by the concerned PHS agency for scientific merit and relevance to health priorities. The work is usually carried out by foreign

investigators in cooperation with a U.S. Project Officer who may be on the staff of one of the health agencies or associated with a U.S. university, hospital, or other institution. Often, the U.S. Project Officer is carrying out similar research in his own laboratory or program and the foreign investigation complements and strengthens his own work. A significant benefit derived by the foreign countries is the opportunity for their researchers to enhance their own capabilities through collaboration and exchange of information with U.S. scientists.

The activities funded by this appropriation support research projects related to the domestic activities of the health agencies. It enables them to take advantage of unusual research opportunities in the excess currency countries; strengthen communication and exchange of information between institutions here and abroad; and, as an ancillary benefit, improve relationships with other countries. Frequently, the cost of conducting the work abroad is less than it would be in the United States. This may be due to factors such as easy accessibility to a study population, the existence of specialized laboratories, the availability of non-human primates for research, language competence, and the like.

Cooperation on health related matters by the United States with the Arab Republic of Egypt and India are expanding. Specifically, a Joint Working Group on Medical Cooperation, for which DHEW has lead responsibility, has been established with the Arab Republic of Egypt. Priority areas for cooperation have been identified and the health agencies are developing a significant number of new project proposals. Similarly, a U.S.-India Joint Cooperation Commission was established in 1974. Within the framework of that Commission, priority areas for cooperation with India in the health field have been identified, and a considerable number of new projects are being developed. A rigorous and productive cooperative health program with the Arab Republic of Egypt and India is emerging, and the tradition of excellent cooperation which the PHS agencies have had with Poland, Tunisia, and Pakistan is continuing. The goals and objectives to be carried out under this Program are:

Alcohol, Drug Abuse, and Mental Health Research

The overall objectives of the alcohol, drug abuse, and mental health research projects supported by this activity continue to be derived from the mission and priorities of the Alcohol, Drug Abuse, and Mental Health Administration; namely, mental and emotional illness.

An effort is being made to develop effective methods of preventing alcoholism and problem drinking through research which will provide a knowledge and technique breakthrough. Comparison of different treatment approaches being utilized in other countries may assist the United States in improving its own programs. A project covering both epidemiological aspects and an evaluation of different treatment modalities is under consideration for development in Poland.

The abuse of drugs is producing increasing social and public health problems in the United States. The widespread use of marijuana and other mind-altering drugs has resulted in the need for diversified research to assess the health consequences of their use. Several drug abuse projects are being planned for the Arab Republic of Egypt, India, and Pakistan, utilizing unique populations.

Mental Health projects being developed include an extension of the nine-nation World Health Organization International Pilot Study of Schizophrenia into the Arab Republic of Egypt and in India biofeedback studies of the relationship between Yogis techniques and neurological and higher nervous functions.

Disease Prevention Research

Research in this category is directed toward prevention or control of communicable and vector-borne diseases, improving laboratory performance, nutrition, and assuring safe and healthy working conditions.

In 1977, emphasis will continue to be placed on collaborative studies of relevance to domestic program objectives, including leprosy, filariasis, malaria, and schistosomiasis.

In the Arab Republic of Egypt, ongoing studies on schistosomiasis and streptococcal diseases will be continued. Studies on diarrheal and parasitic diseases, which will complement research now being conducted at the Center for Disease Control, are under consideration. In the field of occupational health studies of industrial chest diseases will be continued and new research to determine the role of nutrition in increasing tolerance to environmental stress as well as studies of industrial noise will be initiated.

In Poland, studies on immunological responses to Staphylococcal infection and investigations of virus infections, particularly to define the immune responses of influenza and measles will be continued. Chemotherapy studies of newly-detected pulmonary tuberculosis and non B viral hepatitis in Polish children are planned. Studies of the role of arboviruses in human diseases are planned for Pakistan.

Food and Drug Research

Research projects under this activity fall into four broad areas: environmental health, radiological health, medical devices, food research and nutrition.

In this connection, the Food and Drug Administration has responsibility under the National Environmental Policy Act of 1969 for the assessment of the environmental implications of the production, use and disposal of substances subject to its regulatory authority. Moreover, FDA is required to determine the validity of test methods such as experimental ecosystems, which are used to demonstrate the "metabolism" of regulated substances by the environment. To meet this need, FDA is interested in sponsoring collaborative research under this activity which will serve to provide guidance to industry and the agency on research methodologies that may be employed to evaluate the environmental impart of substances subject to its regulation.

Projects conducted and proposed under the Special Foreign Currency Program augment the domestic radiological health program through study and evaluation of the biologic effects and health hazards of exposure to radiation such as X-rays, microwaves and ultrasound. Proposed studies during 1977 will extend these investigations into the field of light radiation exposure.

There is a continuing need to do comparative studies of the safety and efficacy of the contraceptive agents, pills, foams, diaphrams, condoms and intrauterene devices. Studies are being planned to obtain scientific and medical data in order to advise consumers and the medical community.

The excess currency countries are a valuable laboratory for studies of foods and nutrition. During 1977 emphasis will be on problems involving hazards and safety aspects of food or food contaminants. Projects would include studies of nitrosamines; natural plant toxins; mycotoxins; pathogenic bacterial and protozoa contaminants of foods; pesticide residues; toxic elements, such as cadmium, mercury, zinc, arsenic, fluoride, and selenium; and, unconventional proteins as food ingredients. Projects to investigate the teratogenic, mutogenic and caranogenic aspects of food additives and contaminants are also planned.

In the field of biologics, a collaborative research project involving viral vaccines, including the development and control of live polio virus and measles products, is planned for the Arab Republic of Egypt.

Health Services Research

The broad objective of the health services research supported under this appropriation is to improve the quantity and quality of the delivery of health services through problem-oriented research studies. Within this broad frame of reference, specific programs of concern include the provision of health and medical care to areas of need such as barriers to obtaining service; and maternal and child health, with special attention to nutrition and family planning.

The activities proposed for 1977 relate to these program areas include one project in India and three in Egypt aimed at improving the delivery of health services in remote and medically underserved areas and in other areas where facilities are underutilized. A study dealing with emergency medical services is also under consideration.

Several projects concerned with problems of maternal and infant care and of children and youth are under consideration. Egypt has expressed interest in projects relating to premature care, nephrology, and upgrading the renal disease program in the Ministry of Health. A family planning project to test new approaches to the delivery of family planning services as well as examine methodologies for motivating contraceptive users. It is expected that one or two projects will be developed, also in Egypt, dealing with the nutritional problems of adolescent mothers and their offspring. In India a project relating to malnutritional eye diseases is under discussion.

Health Resources Research

The health resources research supported under this appropriation is designed to further domestic research goals and objectives such as the development of additional health resources; improving methodologies for the continuing collection and analysis of data on the health status of U.S. citizens; and, the identification and correction of current and anticipated imbalances, inefficiencies and deficiencies in the distribution, supply, utilization and cost of health resources and services. Some of the areas now being studied under this activity are the training and proper utilization of special categories or professional and allied health manpower, cost reduction on hospitalization, and more resource opportunities for disadvantaged persons.

Comparative studies of foreign health profession eduction systems and manpower planning units and techniques are under consideration for funding in 1977. For example, a feasibility study of a new approach to primary care using village workers is under development in India. Several health manpower projects are currently under development in Egypt, including a program aimed at training secondary-level health teachers in educational, audio visual and evaluative techniques.

In the area of health statistics, a number of studies directed toward improving methodologies for vital registration and statistics development with special emphasis on more accurate indication of the health of population groups are planned. These include a study of the health status and development of school children in Egypt and a study of fetal growth, birth weight and infant growth. The latter project may provide insight into the reasons for the relatively high rate of infant mortality in the United States. Plans are under way to initiate evaluative studies of the effectiveness of urban health care. This is an area of interest to the Department in light of development on national health insurance

and the planning already under way for implementation of the National Health Planning and Resources Development Act.

Biomedical Research and Health Science Communications

The Special Foreign Currency Program is an integral part of the biomedical research and health science communications programs of the National Institutes of Health. It provides a resource whereby both intramural and extramural domestic research programs can be extended into the international biomedical sciences community--in some cases to provide needed augmentation of parallel research efforts of the United States and in other cases to utilize research opportunities not available in this country.

Biomedical research efforts are directed toward the elucidation and understanding of fundamental biological processes in normal life and disease states of man and living experimental models. This activity includes reproductive physiology, nutritional and metabolic mechanisms, cardiovascular disease, cancer studies, as well as communicable and parasitic diseases.

Parasitic infections are a health problem throughout the world, and drug treatment of these infections and chemical control of vectors such as snails and mosquitoes are decreasingly effective. Hence, the immunology of parasitic infections offers a productive new avenue of investigation. Enhancement of immune response to larger parasites offers a potentially effective therapeutic approach and a means of biological control of these debilitating, often lethal agents. Host-parasite relations of these larger organisms, which have not been studied extensively because of their complexity, also offer new models for investigating poorly understood immunological mechanisms for which a unifying theory is needed. Initial studies of some aspects of filarial infection will be undertaken collectively, and the potential for extending collaboration into investigations of the immunology of malaria will be assessed. Other biomedical problems are posed by tuberculosis and leprosy.

The widespread occurrence of bladder cancer in Egypt, associated with infection by the schistosome, a blood fluke, will be the basis for an extensive collaborative investigation. Other forms of cancer will be studied also. An apparently unusually high incidence of stroke in young people in India offers an opportunity for further study of the relationship of diet to cardiovascular complications and stroke.

Emphasis under the health science communication activity will continue to be on translation of important medical literature and publication of critical reviews analyzing current trends in biomedical research and health practice.

Program Purpose and Accomplishments

Activity: Foreign health research (Agricultural Trade Development and Assistance Act of 1954, as amended, Section 104(b); International Health Resource Act of 1960, Section 3)

1976		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	---	Indefinite	---	$1,500,000

Purpose: Collaborative health research and research-related projects abroad are supported by foreign currencies owned by the United States which have been determined by the Treasury to be in excess of normal United States needs in the countries. The program helps achieve the domestic health objectives of the Department and promotes United States foreign policy.

Explanation: The Program is supported entirely by foreign currencies owned by the United States abroad. Payments are made for necessary expenses for conducting research and other related activities, as authorized by law.

Accomplishments in 1976:

During 1976 an estimated $13,124,000 in foreign currencies will be obligated for new and continuations of ongoing activities in six countries. Plans include $3,808,000 for the programs of biomedical research and health science communications, $825,000 for mental health, including drug abuse and alcoholism; $3,125,000 for prevention and control of communicable diseases and occupational health; $1,280,000 for studies focused on food and drug safety, radiological health and medical product safety; $4,086,000 for studies aimed at improving the organization and delivery of health services, health statistics, medical education and other manpower development.

Objectives for 1977:

The 1977 program will be carried out in part with funds appropriated but unused in prior years. Obligations during 1977 are expected to include: $737,000 for mental health, alcoholism, and drug abuse; $3,371,000 for disease prevention and control, including occupational safety and health; $1,072,000 for studies related to food protection, radiological health, medical devices and exchange of information in these areas; $4,173,000 for studies related to the organization and delivery of health services, including health manpower and maternal and child health; and, $4,454,000 for biomedical research and the health science communications program of the National Library of Medicine.

Transition Quarter Analysis

	Amounts Available for Obligation	
	1976 Estimate	Transition Quarter
Foreign Health Research:		
Unobligated balance, start of period	$27,443,000	$14,319,000
Unobligated balance, end of period	-14,319,000	-12,307,000
Total obligations	13,124,000	2,012,000

Funds are required for the transition quarter to enable the health agencies to initiate activities on a timely basis in connection with the U.S.-Egypt Joint Working Group on Medical Cooperation, the U.S.-India Joint Cooperation Commission and the U.S.-Polish Program of Cooperation in the Health Sciences. Each of these Programs involved a Government-to-Government Agreement through which priority areas for cooperation have been identified for support.

CONCLUSION

Dr. COOPER. Mr. Chairman, that concludes my presentation on the budget requests for the items I have listed. I will be pleased to answer any questions you may have.

FORWARD HEALTH PLAN

Senator MAGNUSON. You have submitted a "Forward Health Plan" to Congress which makes recommendations for our Nation's health needs in the future. Please outline for the committee what you consider to be the basic elements of this plan.

Dr. COOPER. In this document we have tried to set forth the major health problems and issues confronting the Nation. Some of these problems are economic, resulting from the rapid rise in health care costs. Others are medical in nature and have to do with the quality and effectiveness of and access to the health care we are providing. Still other problems are social in nature such as the environment and certain aspects of human behavior which impact on the prevention of health problems. Finally, some of our most basic problems stem from a lack of knowledge about certain diseases.

For each of these problem areas, we are recommending specific proposals in the budget to address them. For example, there are no easy answers to the problem of rapidly rising health costs. However, speeding up implementation of the PSRO program and the Health Planning and Resources Development Act will, in my judgment, have a favorable impact in this area. These two programs are also intended to cope with quality and effectiveness of care problems. The National Health Service Corps and the proposed Health Professions Education Act are related to providing quality and effective care, and improving access to care.

Social problems which impact on health care are becoming increasingly important. We must continue to emphasize environmental research, and related efforts such as the development of criteria standards for the workplace by the National Institute for Occupational Safety and Health, and then follow up on the results of this research. We must concentrate on individual action to prevent diseases and other prevention efforts, such as those under the direction of the Center for Disease Control and the Food and Drug Administration.

We must emphasize biomedical, behavioral, and health services research and provide for balance within these categories so that those specific areas of apparent opportunity will receive commensurate resources.

Senator MAGNUSON. Does your budget make any headway in carrying out the recommendations of that plan?

Dr. COOPER. The budget does make some headway in carrying our recommendations of the forward plan. For example, in the prevention area, we are emphasizing resources for both NIOSH and laboratory improvement to improve safety in the workplace and the quality of clinical laboratory testing. In the case of research, the budget of $2.2 billion for the National Institutes of Health will enable us to make significant progress. In the cost containment category, our request of $62 million for Professional Standards Review Organizations will provide for organizations in all 203 designated areas. In the health plan-

ning program, the $90 million budget request will provide funding for all 211 Health Systems Agencies (HSA's), including full designation of 111 of these organizations. So, in these and other areas, the budget request does make progress in carrying out the recommendations of the forward plan.

FORWARD HEALTH PLAN

Senator MAGNUSON. What would it cost, in your professional estimate, for a reasonable implementation of the Forward Health Plan in fiscal 1977?

Dr. COOPER. That figure would be about $6.3 billion, the amount we proposed to the Department in our fiscal year 1977 estimates. This would include $5.7 billion for those programs considered by your committee plus approximately $405 million for the Indian Health Service and $257 million for the Food and Drug Administration.

IMPROVED HEALTH SYSTEM FROM INDIVIDUAL ACTION

Senator MAGNUSON. Your health plan indicates that an improving health system could come from individual action. Please explain this, and let us know how you are going to encourage this.

Dr. COOPER. An overwhelming portion of disease and death today are caused by man or his institutions and can be prevented or controlled by man. Heart disease, diseases induced by environmental causes, cancer, stroke and major disability, for example, result primarily from such underlying causes as smoking, excessive alcohol, inappropriate or excessive food consumption, toxic substances in our air, food and water or in the workplace, and automobile accidents. We can control these events. But they are not for the most part preventable by direct medical intervention as with immunization against communicable disease. To prevent them requires, in many cases, changes in individual behavior. In other cases, it requires legislative action which can be encouraged by an enlightened citizenry.

ACCOMPLISHMENTS OF FORWARD HEALTH PLAN

Senator MAGNUSON. We would like to better understand the purpose of the Forward Plan for Health, to which we know many staff hours of time are devoted. It seems to us to be a "plan" only in the loosest sense because it contains few specific goals or methods and resources required to attain these goals. What specific accomplishments are being made in fiscal year 1976 in areas highlighted by last year's "make work" project?

Dr. COOPER. Let me first say that I do not, by any means, consider this a "make work" project. The Forward Plan for Health was intended to chart the major directions the Public Health Service would take in fiscal year 1976 and beyond and is really a plan in the best sense of the word. A number of recommendations have been implemented. Let me give you a few examples. Our recommendation for a National Commission on Biomedical Research which we had planned to create administratively was in fact implemented by the congressionally created Presidents Panel on Biomedical Research. It is already having an impact on the direction of our research efforts. Similarly, our recom-

mendation for increased attention to the protection of research subjects is being implemented through the work of the National Commission for the Protection of Human Subjects.

Our efforts to address health manpower problems especially those related to specialty areas, geographic maldistribution, and primary care, were embodied in the proposed manpower legislation, the Health Professions Education Amendments of 1975. Our emphasis on the need for an improved planning system at the State and local level is well on its way with the implementation of the Health Resources Planning and Development Act. Our efforts to initiate a rural health program have led to the integration of a number of rural health projects. Our planning efforts have been instrumental in advancing the implementation of the PSRO program. We have also been very involved in assessing the results of peer review. These are just a few examples of the many areas where our planning efforts have led to direct action to improve the health care system.

The forward plan is also the basis for our budget proposals to the Secretary, HEW, to OMB, and to the Congress. I require the administrators and directors of these health agencies to specifically relate their forward plans to their budget recommendations to me. Of course, as you know, the budget process is a dynamic one. We are operating with limited resources, and there is, should I say, some differences of opinion on how much money is necessary and what should be emphasized. Our system provides for decisions by the Secretary, subsequent decisions by the President, and, as you know, action by the Congress. What results is often very different than what we started with. But to start with a "plan" is essential.

ENVIRONMENTAL HEALTH

Senator MAGNUSON. It seems as if every Federal agency is developing some sort of environmental health program. What kind of progress are we making to insure no duplication of these programs?

Dr. COOPER. The current emphasis on environmental health is, I believe, a very good idea. If we can identify those environmental agents which cause disease and then prevent human exposure, we are practicing the best medicine—preventive medicine. Environmental health problems, however, have many facets and cover a very broad area. For this reason there are a number of different HEW agencies, as well as other agencies, with legislated authority in this area. Some focus exclusively on environmental problems. For example, the National Institute of Environmental Health Sciences strives to advance fundamental knowledge of the effects of environmental agents on man's health, while the Environmental Protection Agency takes action to develop standards and regulations regarding such agents. Other agencies may become involved in environmental problems as a result of their responsibilities. For example, the National Cancer Institute must be concerned with causation of cancer due to environmental factors, and the National Institute for Occupational Safety and Health is concerned with occupational problems related to such factors.

Often what appears to be duplication, when defined in broad categories, is really complementary research. For example, research may

be carried out by two agencies on the same problem but, because of their different responsibilities, the focus of their research is different. This can result in their developing different facts that could help solve some environmental health problems, or in their developing complementary findings that confirm the work and could lead to the development of preventive measures.

I am convinced that work in the environmental health area must be undertaken in a coordinated way. In 1973 my predecessor, Dr. Charles C. Edwards, established the DHEW Committee to Coordinate Toxicology and Related Programs which I strongly support today. The committee was to provide a medium to assure exchange of information on toxicology and related programs, to coordinate these programs, to enhance sharing of resources, and to provide advice to the Department. Agencies outside the Department such as the Environmental Protection Agency and the Consumer Product Safety Commission are routinely involved in the activities of this committee. It has been successful in achieving these aims and it does provide an informal mechanism to insure coordination in environmental health throughout the government. As a result of the committee's continuing review of the activities of the HEW agencies, I am convinced that there is no significant duplication. Further, there is a high degree of interrelation between the activities of the several agencies.

Further, the National Institute of Environmental Health Sciences has sponsored a number of conferences on critical environmental health problems, including polychlorinated biphenyls, chlorinated dibenzodioxins, low-level lead toxicity, ingested asbestos, and vinyl chloride. These conferences bring together scientists from Government, industry, and the academic community to learn what work is underway on the problems and who will do any additional needed research. To insure that the findings of these conferences are widely disseminated, the proceedings are published in the NIEHS journal, Environmental Health Perspectives, which is distributed to those in environmental health professions as well as to others interested in this area.

Proper planning is a major element of proper coordination. I think it is particularly important therefore that the National Institute of Environmental Health Sciences, at the direction of Congress, has chartered a task force to address the problem of needs in environmental health research. The task force will be bringing together many scientists from government and nongovernment agencies, and this effort in itself should lead to better coordination, but more importantly it will provide a blueprint for the current and future research needs in environmental health.

Although we have made progress, we need to go still further in our efforts to coordinate. In our Forward Plan for Health for fiscal year 1977–81, we have indicated that the Public Health Service should develop a major policy paper on its role in environmental health research. A major aspect will deal with coordination.

KEPONE INCIDENT

Senator MAGNUSON. What can we do to see to it that no more disasters like the Kepone incident are repeated, and what are your responsibilities in this area?

Dr. COOPER. In reviewing the events surrounding this incident, it is obvious that we need better access to information about potential health hazards and we need to respond more quickly once we are aware that a hazard exists. We have met with representatives from the Occupational Safety and Health Administration, the Food and Drug Administration, and the Environmental Protection Agency to set up procedures for sharing information and coordinating responses to health emergencies. There are approximately 100 pesticide manufacturers in the United States, about 3,000 formulating operations and tens of thousands of applicators. Although there is ample information on the effects of pesticides on pests and some information on the acute effects on man, little is known about chronic effects of human exposure to most pesticides. It is important that cancer-causing pesticides be identified and controlled as soon as possible. As a part of the total Federal effort to gather such information, the National Institute for Occupational Safety and Health will conduct an industrywide study of pesticide formulators.

For several years the National Institute for Occupational Safety and Health, the Environmental Protection Agency, and the National Institute of Environmental Health Sciences have supported research grants to develop an understanding of the mechanism of insecticide decay.

The National Institute for Occupational Safety and Health is working cooperatively with the Environmental Protection Agency on a project to determine whether long-term low-level exposure to pesticides is associated with neurol gical or behaviorial changes. An agreement with the Environmental Protection Agency will provide the opportunity for each agency to review the regulations or recommendations of the other before they are issued.

POSITIONS

Senator MAGNUSON. What is the status of the 881 positions specifically added to the 1976 bill?

Dr. COOPER. The Senate add-on of 881 positions, representing increases over those authorized in fiscal year 1975, was subsequently superseded by action of the conference committee in providing for 750 positions above the 1975 level. These positions were not allocated pending final disposition of the Labor-HEW appropriation bill. Now that this matter is finalized, we are in the process of requesting OMB to approve additional ceiling consistent with congressional intent. These positions will be utilized as indicated by the Congress for research, services, and grants and contracts management.

HEALTH BLOCK GRANTS

Senator MAGNUSON. Please give the committee a brief summary of what the administration's new health block grant proposal is all about.

Dr. COOPER. The health block grant proposal, which is known as financial assistance for health care, consolidates 16 public health service, medicaid and developmental disabilities programs into a new $10 billion health grant to the States for service programs to benefit the poor, the handicapped and the disadvantaged. Legislation would pro-

vide for a $10.5 billion authorization level in fiscal year 1978 and $11 billion in fiscal year 1979. This consolidation is intended to give States and local governments flexibility in determining funding priorities, simplify program administration at both Federal and State levels; eliminate any inequities in Federal funding; allow the States to focus Federal resources on the poorest and most disadvantaged; and eliminate required State matching.

Senator MAGNUSON. This block grant scheme would place primary responsibilitity for many health projects on the shoulders of State and local governments—is that correct?

Dr. COOPER. Yes, Senator, that is correct. This is based on the belief that States and local governments are in a relatively better position to know what their health care needs and priorities are. These priorities could tend to vary among States. The proposal would give States and local governments more discretion in these matters.

Senator MAGNUSON. How can we be assured that the States are, or can be, geared up to handle these projects?

Dr. COOPER. Of course, we cannot be completely sure. However, the States are administering these programs already. Their efforts will not be profoundly more significant. In addition, we will propose under the legislation that is being drafted that a State health care plan be required. This plan would assure that all citizens of the State, particularly the poor and medically underserved have access to needed health services of acceptable quality. The plan would also require the development and utilization of preventive health services, the encouragement of the use of ambulatory care in lieu of inpatient services, and the provision of primary care services especially for those located in rural or medically underserved areas.

Senator MAGNUSON. Last year you said that the States, localities, and third-party payers would assume 20 percent of the cost of the federally supported health service projects. Did this actually happen?

Dr. COOPER. It is too early to give any categorical answer to this question. However, while there have been some increases in State, local and third-party contributions in some programs, there has not been any observable trend in this direction. We are going to continue, however, to emphasize greater third-party reimbursements where appropriate.

Senator MAGNUSON. The States have been cutting back medicaid entitlements to reduce costs. The block grant proposal will result in the States having to absorb a greater share of the medicaid costs. What evidence do we have that the States can absorb the costs?

Dr. COOPER. There is little or no evidence. The total amount included in the medicaid budget for the block grant in 1977 is $9.3 billion, which is $1.1 billion more than was appropriated in 1976 (including the pending supplemental request) and $2.2 billion more than was actually spent in the fiscal year which ended last June. It is too early to tell whether this amount, and the proposed increase of $0.5 billion per year will be sufficient to meet the needs of the States.

MIGRANT HEALTH

Senator MAGNUSON. How are we going to asure that projects such as migrant health will be funded by the States under the block grant proposal?

Dr. COOPER. There is, of course, no assurance over the long term. In order to protect projects like migrant health, we are proposing a gradual phase-in of block grants. During this transition period direct Federal grantees such as migrant health centers, would be protected to some extent from large budgetary reductions during the first 3 years of the program. Grantees would be guaranteed at least 80 pe cent of their fiscal year 1977 grant level in the first year, 50 percent in the second year, and 25 percent in the third year. In addition, we would propose regulations which would prohibit the States from imposing duration of residence requirements as a condition of participation in order to protect populations such as the migrants when the grants are fully State-administered.

We would hope, naturally, that States with large numbers of migrants would treat this as a priority problem and devote more resources to it, not less.

HOLD-HARMLESS PROVISION IN BLOCK GRANT

Senator MAGNUSON. It is very likely that the formula for disturbing the block grant will result in some States Like New York and California receiving substantially less funds. Will the new law provide a hold-harmless provision which will assure no less of funds to such States?

Dr. COOPER. Legislation is being proposed which would insure that no State would receive less in 1977 than it did in 1976. Under the present system of matching grants and the categorical eligibility structure, some of the States with the highest per capita income, such as New York and California, receive more than four times as much Federal money per poor person as do States with low per capita income. After an initial period of transition, we would propose that funds be distributed according to a formula giving primary weight to the relative "tax effort" made by a State and to a State's per capita income. Under this proposal, the poorer States would realize the greatest increases in the share of total Federal assistance.

Senator MAGNUSON. How would the oversight of the block grant proposal be carried out? Who will monitor the State plans? Who will determine if the States are in compliance with their plans? How will the data to make this determination be gathered? Who will provide the technical assistance materials and guidelines to the States as mentioned in the HEW fact sheet on the proposal?

Dr. COOPER. Senator, the details necessary to answer these questions have not been worked out yet. The legislative proposal does include a staff of 100 persons to provide the administration and oversight for the program.

Senator MAGNUSON. The Federal Government assumed the role of initiating and supporting the various PHS health service programs because it was felt that people weren't getting the health services they needed, that the services weren't available in many communities and weren't avaliable to low-income and minority populations. The States presumably did not see these health needs as a priority, or did not have the funds or the administrative capability, because they did not initiate these programs on their own. What guarantee do we have that these worthwhile projects will be continued as Federal funding of these programs diminishes?

Dr. COOPER. We are not proposing a diminishing level of funding. However, there is no guarantee that the individual projects will continue to be supported at current levels. However, we hope that the need for these programs, as well as their worthiness, will be recognized by the individual State governments and the citizens of the individual States. We believe that in most cases they would be continued. On the other hand, we would expect that if a particular State sees its priorities differently, that State might make a significant change in the types of projects that are funded.

EFFECT OF GRANT PROPOSAL ON HEW EMPLOYMENT

Senator MAGNUSON. Could you please explain the effect your consolidated grant proposal would have on HEW employment? How will this look agency by agency? Why are an additional 100 positions, for $1.5 million, being requested for the Office of the Assistant Secretary for Health as part of the proposed legislation? How do the regional offices fit into this plan?

Dr. COOPER. If the block grant proposal for health is accepted, there would be a reduction in the requirement for Federal employees to administer these health programs. There would be an overall reduction of approximately 2,400 positions offset by 100 positions to administer the program for a net reduction of approximately 2,300 positions. Since a substantial number of the programs that would be consolidated into the block grant are administered by the regional office now, the adoption of the block grant would result in a decrease in regional office employment. With your permission, I will insert into the record an agency by agency breakdown of the position decreases.

[The information follows:]

Fiscal year 1977 block grant proposal position reductions

Health Services Administration	−619
Center for Disease Control	−413
Alcohol, Drug Abuse, and Mental Health Administration	−175
Health Resources Administration	−367
Total, PHS	−1,574
Social and Rehabilitation Service (medicaid)	−816
Office of Human Development (Developmental disabilities)	−61
Total position reduction	−2,451
Staff to administer block grant	+100
Net position reduction	−2,351

CEILING ON INCREASES FOR BLOCK GRANT PROPOSAL

Senator MAGNUSON. Placing a ceiling on increases for the block grant proposal of $0.5 billion per year may be an effective way of holding down Federal health spending, but what will be the effect on individual grantees such as neighborhood health centers, migrant health projects, and other of our important health service projects in communities? What will be the effect on the people, especially the low income people, who are being served by these projects?

Dr. COOPER. After the initial phasein period, the future of individual grantees would be up to the States who will most likely be under pressure to control costs in order to preserve service levels. Perhaps some States would choose to combine some of these projects, such as community health centers, family planning projects, and mental health centers into a more efficient and less costly statewide system of comprehensive health centers which would provide a broad range of services to all categories of low income individuals. Perhaps some States would opt to continue to fund the existing grantees. The people served will be dependent on the States controlling costs or increasing resources, or a combination of the two. If service levels have to cut back, the health of these people would be adversely affected.

PUBLIC HEALTH SERVICE HOSPITALS

Senator MAGNUSON. As you know, Congress has repeatedly mandated that the PHS Hospitals be kept open. Now, your budget proposes closing them again. What evidence do you have that the closure would be approved this time?

Dr. COOPER. We have no evidence, Mr. Chairman, but we do hope that Congress will support transfer to communities or closure after thoughtful consideration of our reasons. For example, these facilities are being used at only 69 percent of their capacity and only 53 percent of our patients are primary beneficiaries. Alternative care for current PHS patients is available in hospitals of the communities where PHS beneficiaries are situated. Moreover, there are excess hospital beds for community needs in areas where five of the eight PHS hospitals are located. By absorbing the Public Health Service workloads, it would assist these communities in more effectively utilizing their own hospital facilities.

Senator MAGNUSON. The law requires that States and local health planning agencies approve the closing. What evidence do you have that the planning agencies will approve the closing?

Dr. COOPER. As in the case of the Congress, Mr. Chairman, we have no evidence from the planning agencies that they will approve the transfer to community use or closure. A letter explaining the administration's proposal has been sent to all State and local planning agencies requesting their approval of the transfer. We believe that after seeing our reasons for transfer or closure, they will give us their support. However, I do wish to assure the Congress, we shall continue to operate these hospitals and provide quality care with no reduction in services.

Senator MAGNUSON. Why do you plan to close PHS hospitals and use contractual arrangements when contract care will be more expensive?

Dr. COOPER. The decisions to transfer to community use or to close the PHS hospitals and to provide inpatient care in community hospitals under contractual arrangements were not made on the basis of the cost of that contract care. We think that there are better ways to deliver health care to our beneficiaries. We believe that in each community, where a PHS hospital now is located, the total community medical care system would benefit by maximum utilization of its available hospital beds, and its professional manpower.

After considering all factors related to continuing the operation of the eight hospitals, we have concluded that the better course of action would be to close these facilities or transfer them to community control.

ST. ELIZABETHS HOSPITAL

Senator MAGNUSON. St. Elizabeths Hospital has now lost its accreditation because neither the District of Columbia or the Federal Government is willing to take responsibility for this institution. What are your plans to help the hospital regain its accreditation?

Dr. COOPER. Several things are underway, which address the three broad areas of facilities, staffing, and management. First, let us look at facilities. The Joint Commission on Accreditation of Hospitals, or JCAH, found the St. Elizabeths facilities overcrowded; lacking in certain safety features; deficient with respect to patient privacy; and lacking in the provision of certain service features for patients. To meet these problems, we have taken several steps. First, we reprogramed $1,260,000 in facility improvement funds last year, to meet the most urgent needs relating to safety, privacy, and services. Some of these funds are also being used for a planning study for the purpose of determining the most effective deployment of facilities required to relieve overcrowding. We are also requesting $5,200,000 in supplemental funds this year, in addition to the $5,400,000 appropriated by Congress, to complete the safety, privacy, and service improvements, as well as to develop plans and specifications for construction or renovation of the facilities required to relieve overcrowding. In addition, the 1977 budget reflects proposed legislation to provide $75 million to move ahead with the actual work of renovating or constructing facilities for the relief of overcrowding.

Concerning staffing, the JCAH identified housekeeping, nursing at both the professional and mental health worker levels, pharmacy, and occupational and recreational therapy as the areas needing more support. Several actions are being taken to address the staffing issue. We are requesting a supplemental appropriation to support the additional 104 positions provided by the Congress in the 1976 appropriation act.

The last issue relates to internal management. The JCAH cited several problems in this broad area, the bulk of which related to documentation of procedures and maintenance of patient records. Correction of these deficiencies is well underway, and no additional funds or positions will be required to complete the work.

Senator MAGNUSON. How can the Federal Government insist on strict interpretation of regulations for hospitals when it cannot even maintain accreditations in its own hospital?

Dr. COOPER. The inconsistency of the situation as it relates to St. Elizabeths Hospital is certainly a cause for concern. However, I would like to offer a few observations. First and most important, during their last three visits, the Joint Commission on Accreditation of Hospitals found much that was good. The commission was deeply impressed by the level of dedication and personal commitment displayed by the hospital staff.

The loss of accreditation was the product of several forces. First, the development and application of standards specifically to psychiatric facilities is a relatively new process. In a situation of this type,

it is difficult to know whether an institution should be judged in relative or absolute terms. However, when judged by ideal standards, it has a long way to go. Second, any publicly funded institution must deal with the realities of the budgetary process. We are limited by competing priorities and normal delays between the recognition of a problem and the availability of funds to correct that problem. This is an important point; because even during the process of disaccreditation, steps were being taken to correct many of the deficiencies which had previously been identified by the JCAH. These actions were not sufficient to head off what happened, because accreditation bodies look for physical progress, such as awarded contracts and work in place. The final point I would like to make relates to the future of the hospital. The patients at St. Elizabeths are entitled to the best whether the hospital is run by the District or Federal Government. However, the total mental health strategy of the community has a fundamental effect upon the type and location of facilities to be constructed. For the past 12 years, uncertainties over the future of the hospital, and therefore the future shape of its physical plant, have delayed needed improvements. We are hopeful that this period of uncertainty is behind us now.

INTERMEDIATE FACILITIES FOR ST. ELIZABETHS PATIENTS

Senator MAGNUSON. What are the plans of HEW to implement the court order of a few weeks ago requiring that intermediate facilities be provided for patients that should no longer be in St. Elizabeths? Will the funds provided in 1977 be used for such facilities?

Dr. COOPER. We have been working with the District in identifying the number of patients that would benefit by being transferred to what the court termed less restrictive alternative facilities. Such identification considers patient's age, sex, and type of care required, such as nursing homes, halfway houses, and foster homes.

We have identified approximately 1,300 patients in the hospital that we consider eligible under the court order to be transferred to less restrictive alternative facilities.

On July 1, 1976, a new set of social security amendments will be implemented under Public Law 92-603. We are analyzing the effect these amendments will have on making more existing facilities available. We also plan to find out what influence, if any, they would have on the private development of additional nursing home facilities.

The District and Hospital have been actively seeking outpatient resources for several years. While many patients have been placed, there are no facilities available within the District to accommodate more than a very small portion of the 1,300 available for transfer. We therefore cannot depend on existing facilities to accommodate them. We are not at this time able to provide any insight as to what facilities may be available in the metropolitan area. However, we will be investigating that area in the near future. The increase in remuneration for medicaid patients, to be effective July 1, 1976, may make some beds available. However, the major need is the development of a significant number of new facilities. This can be accomplished only through the expenditure of private and/or public funds for the construction of new and/or remodeling of existing facilities.

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One of the major reasons for the Joint Commission on Accreditation of Hospitals removing accreditation was the severe overcrowding of patients. The transfer of 1,000 to 1,300 patients to less restrictive facilities would relieve this problem. We are beginning a site survey at St. Elizabeths in April to determine new construction and remodeling requirements to assure accreditation of the Hospital. The site survey will be coordinated with the recent court decision ordering the transfer of patients to less restrictive facilities. The Department plans to introduce legislation within the next 3 months which would address the transfer of St. Elizabeths Hospital to the District of Columbia. Included will be $75 million Buildings and Facilities authorization for the hospital in order to regain JCAH accreditation. We hope that both authorization and appropriation language will provide us with sufficient flexibility in the expenditure of the funds to address all issues, including the Hospital's accreditation problems, court directives, and the plans and eventual transfer of SEH to the District. We hope to address all of these things as a single package, and not have to attempt separate solutions to each.

ADAMHA ADMINISTRATION

Senator MAGNUSON. You have proposed dratic cutbacks for the alcohol and mental health programs—yet, increases for the drug abuse program. What is your rationale for this?

Dr. COOPER. Drug abuse programs are proposed to increase for several reasons. First, the Federal Government has a considerably larger role in the funding of drug abuse treatment and rehabilitation activities. At the present time, we support approximately 35 percent of the Nation's drug abuse treatment capacity. Second, as the "White Paper on Drug Abuse" cited, there has been an increase in the incidence and prevalence of drug abuse. Treatment waiting lists reappeared in 1975 after being practically nonexistent for 15 months. Simultaneously, the utilization rate of treatment slots increased and is expected to be at 100 percent by June 1976. As a result, funds for 7,000 new slots have been requested. Third, drug abuse is unique in that efforts must be made to coordinate the law enforcement aspects of drug abuse with the treatment and rehabilitation efforts. This can be done most effectively at the Federal level.

In comparison, in the alcohol community program, we are proposing to limit grantees to 3 years of Federal support, thereby decreasing fiscal year 1977 funding requirements. In Mental Health, we are not at this time proposing to implement the Community Mental Health Centers Amendments of 1975. This decreases our fiscal year 1977 funding requirements.

In all three of these activities, we are proposing to phase out clinical training and predoctoral research training. In addition no new awards are proposed for postdoctoral training.

NIH CONSOLIDATION

Senator MAGNUSON. This year the budget proposed a consolidation of all NIH programs into one appropriation item. Why was this done?

Dr. COOPER. The new consolidated appropriation request has been prepared to streamline the budget formulation and review process, to provide consistency with other health program appropriations which have been combined in recent years, and to reflect more accurately the way in which the President's decisions on NIH funding are actually made. Our proposal would consolidate 15 of the 16 separate NIH appropriations, but would leave the buildings and facilities account separate since the construction funds provided in this appropriation are available for periods longer than 1 year.

Senator MAGNUSON. Don't you think this would take away a great deal of visibility for each Institute?

Dr. COOPER. Not really. The consolidated appropriation request contained in the budget still separately identifies the amount proposed for each individual Institute. It's our belief that the consolidation of NIH's appropriations does not change the individual relationship which each Institute has with Congress. Our experience with the consolidated appropriation for the Three Institutes of the Alcohol, Drug Abuse, and Mental Health Administration shows that Institute Directors can continue to present their programs for review by your committee even though funding is consolidated. We think this can be the case for NIH as well. In addition, it has always been my belief that the Institutes receive most of their visibility as a direct result of the quality of research that they support. When a scientific breakthrough occurs, the individual Institute that makes the contribution will continue to be recognized as it has in the past. Whether the Institute receives its support from a consolidated appropriation or from an individual appropriation does not affect its organizational visability or its operational effectiveness.

Senator MAGNUSON. What are the advantages of this proposal over the way in which we have always done it—appropriated for each separate Institute?

Dr. COOPER. I think there are several advantages. First, I think the consolidated request presents a better overview of the entire NIH appropriation, something that can be obscured as we look at each separate request. Second, the new structure can serve to ease the administrative burden for both the administration and the Congress in making funding decisions for NIH by allowing similar activities to be arrayed and analyzed across Institute lines. I think these are both important considerations in view of the rather tight deadlines and firm budget ceilings the committee may have to meet in carrying out the new Budget Reform Act. I know the consolidated appropriation will help us in preparing these requests for your review.

Finally, as you know, there are many activities carried out by each of the Institutes which are essentially similar. The consolidated approach would allow the committee to consider these similar activities at one time, thus allowing the committee to have more time to concentrate on the distinctive features and issues involved in each Institute program.

CONSULTANTS

Senator MAGNUSON. How much does each health agency, and your office, spend on consultants each year?

Dr. COOPER. In 1975, the health agencies obligated $2,222,020 for appointive consultants. We are currently developing estimates for

fiscal years 1976 and 1977 which will be submitted to the Congress as required in the Senate report. These estimates will include appointive consultants and contracts and grants with profit and nonprofit making firms. Also, we are developing a review and control system to insure against potential abuse in the use of outside consultant services. I will be happy to provide you with a breakout of our obligations by agency.

[The information follows:]

	Appointive consultants
Health Services Administration	$326,835
Center for Disease Control	32,397
National Institutes of Health	1,054,828
Alcohol, Drug Abuse, and Mental Health Administration	317,844
Health Resources Administration	284,140
Office of the Assistant Secretary for Health	205,976
Total	2,222,020

EVALUATIONS

Senator MAGNUSON. How much are you planning to spend on program evaluation costs in all of the health agencies in fiscal 1977? Be specific for each agency.

Dr. COOPER. We estimate that $14 million will be spent from the following agencies: Alcohol, Drug Abuse, and Mental Health Administration, $1,473,000; the Center for Disease Control, $331,000; the Health Resources Administration, $1,593,000; the Health Services Administration, $3,593,000; and the National Institutes of Health, $7,010,000.

INCREASES OVER 1976 BILL

Senator MAGNUSON. You are requesting an increase of nearly $2 million over the amount Congress provided the Office of the Assistant Secretary for Health in fiscal year 1976—why, when other health service and research programs are being cut?

Dr. COOPER. This increase covers two appropriations—"The Office of Assistant Secretary for Health" and the "Scientific activities overseas" appropriation. For the "Scientific overseas" appropriation we are asking for $1.5 million to fund health research projects in foreign countries using U.S.-owned excess foreign currencies. The 1977 request for $1,500,000 coupled with the $12,307,000 of prior years unobligated appropriated balance carried forward will support a total program of $13,807,000. The remaining increase of $469,000 is required for mandatory costs in the "Assistant Secretary for Health" appropriation. The individual mandatory items of costs are $195,000 for within-grade increases, $156,000 for the October 1975 pay raise funded for only a portion of 1976, $56,000 for space rental charges to be paid to the General Services Administration, $78,000 for services provided by the PHS service and supply fund, $18,000 for postage rate increases funded for only a portion of 1976, and $6,000 for telephone rate increases. These increases are partially offset by a reduction of $40,000 for 1 less day of pay in 1977.

ABSORPTION OF OFFICE CUTS

Senator MAGNUSON. Please give the committee a specific description of just how the cuts in your office are being absorbed.

Dr. COOPER. To achieve the congressional reduction of $2,446,000 from the Assistant Secretary for Health 1976 budget request, 36 positions were eliminated, 102 positions were transferred to the PHS agencies to support their ongoing health programs, and 11 positions were moved to the PHS service and supply fund to support the direct service functions of the Health agencies. These reductions, totaling 149 positions, were offset by the acquisition of 13 positions from the previous centralized personnel services function performed by the Parklawn Personnel Division and the transfer of 4 positions from the Office of the Secretary in support of the long-term care enforcement standards.

In addition to the reduction of $2,206,000 in personal services associated with the elimination and transfer of positions, the standard level user charges paid the General Services Administration have been reduced by $146,000, a reduction of $77,000 was made in travel funds, and $17,000 was eliminated in equipment purchases.

Senator MAGNUSON. Are you transferring any functions and people to other health programs?

Dr. COOPER. Yes; all of the 102 positions transferred to the PHS agencies represented functional transfers. Specifically, 61 regional office grants management positions were transferred to the agencies to be consolidated with their staff performing the same function; 35 positions were transferred to HSA to be a part of their current staff performing professional standard review organization and medical care standards activities, and the remaining 6 positions were transferred to each of the PHS agencies in order to decentralize the reports clearance functions required by the Office of Management and Budget.

Senator MAGNUSON. It was congressional intent that your office be reduced while more positions and funds are made available to the Health programs for their use as they see fit. How are you complying with this intent?

Dr. COOPER. Yes; we have transferred 102 positions to the Health agencies that were formerly included in and funded from funds appropriated to support my staff office.

SECOND SUPPLEMENTAL PAY COSTS

Senator MAGNUSON. You are requesting an additional $470,000 for pay costs in the second supplemental. In light of congressional decreases for the Office of the Assistant Secretary for Health, why are these funds necessary?

Dr. COOPER. The additional $470,000 for pay costs represents funds required for the October 1975 pay raise after the elimination of those positions associated with the congressional reductions.

REDUCTION OF STAFF

Senator MAGNUSON. What have you done to reduce the number of employees in your office?

Dr. COOPER. In fiscal year 1976 we have eliminated 36 positions. An additional 102 were transferred to the PHS agencies to augment their current staff, and 11 positions were moved to the PHS service and supply fund which supports direct service-type functions for the Health agencies. On the other side of the coin, we have made a

few transfers into the office—13 positions due to the decentralization of the Parklawn Personnel Office and 4 from the Department's General Departmental Management account to support the long-term care enforcement standards.

The net result of these transfers has been a reduction of 132 positions from the figures you saw last year.

JUST TRANSFERS

Senator MAGNUSON. Are you just transferring people around, or are you making real cuts?

Dr. COOPER. We are doing both—36 positions have been eliminated and as I indicated before 102 have been transfered to the individual Health agencies to be incorporated with their current staff.

LONG-TERM CARE

Senator MAGNUSON. What actions has the Department taken to evaluate the quality of care being received by the many formerly institutionalized mentally disabled persons placed into skilled nursing and intermediate care facilities?

Dr. COOPER. Since passage of the intermediate care program under medicaid the Department has become concerned over a trend toward placement of mentally disabled persons in skilled nursing facilities and general geriatric intermediate care facilities. The medicaid program, by law, may not discriminate by diagnosis and mentally disabled persons are subject to the same quality controls as any other skilled nursing facility or intermediate care facility medicaid recipient. Prior to authorization of skilled nursing facility services, each patient must have an initial medical review to determine the adequacy of placement and then a reevaluation from the standpoint of adequacy and quality must be done at least annually. Prior to admission to an intermediate care facility, all recipients must undergo an independent professional review to determine the adequacy and correctness of their placement in such a facility. Each individual receives a comprehensive medical, social, and where necessary, psychological evaluation. Reevaluations must be performed at least annually. The State professional review activities fall under the utilization control activities of the Social and Rehabilitation Service. I understand that validation by the Social and Rehabilitation Service of State medical reviews and independent professional reviews is currently in process.

OFFICE OF LONG-TERM CARE STANDARDS ENFORCEMENT

Senator MAGNUSON. What efforts have been made by the Department's regional offices on long-term care standards enforcement to evaluate the appropriateness of discharge plans for persons released from institutions for the mentally retarded that participate in the medicaid program?

Dr. COOPER. The Office of Long-Term Care Standards Enforcement in the regions do not have a mandated role in evaluating the appropriateness of discharge planning. This activity is the direct responsibility of the medicaid single State agency and is performed by its medical review teams. However, the Offices of Long-Term Care Standards En-

forcement do monitor the surveying and certification by State survey agencies of intermediate care facilities for both the general population and the mentally retarded. In carrying out that function our regional staffs do review survey documents to determine if post deinstitutionalization plans have been included in the residents' plan of care. Usually this monitoring is conducted at the regional offices by reviewing survey and certification documents submitted by the State survey agency. Whenever possible, the Office of Long-Term Care Standards Enforcement staffs make onsite reviews.

MENTAL HEALTH CARE TRAINING

Senator MAGNUSON. What training in the mental health area has been provided to the staff of the Office of Long-Term Care Standards Enforcement?

Dr. COOPER. Our staff in the Offices of Long-Term Care Standards Enforcement have not received training specific to mental health primarily because their areas of responsibility do not include mental health facilities. While not related to mental health, training has been provided in mental retardation to increase understanding of the needs of the mentally disabled. Shortly after the skilled nursing facility, intermediate care facility and intermediate care facility-mental retardation regulations were published in January 1974, the Department planned and implemented an extensive training program for regional office and State survey agency staffs. Nine 3-day sessions were held in nine different sites and all regions participated in the training sessions. Five formal training sessions of 5 days in length were conducted by Tulane University at university-affiliated centers for Federal and State mental retardation personnel in the fall of 1974. They were also attended by staff of the Offices of Long-Term Care Standards Enforcement. In 1975 similar training was provided to Office of Long-Term Care Standards Enforcement and State survey agency staff in DHEW regions III and VIII, and is available upon request by the regional office as needed. This training is conducted as a workshop covering the intermediate care facility-mental retardation regulations and guidelines and their application in intermediate care facilities-mental retardation.

Consultation is also available from the Department's Assistant Coordinator for deinstitutionalization of the mentally retarded. To date, Office of Long-Term Care Standards Enforcement regional staff in three regions have received this service and two other regions have requested assistance from this consultant.

Other training provided by or for the Office of Long-Term Care Standards Enforcement staff incluudes: The use of the self-study multi-media surveyor training course developed by the University of Oklahoma, intensive training in several areas of the intermediate care facility-mental retardation regulations conducted a region IV's annual surveyor conference in June 1975, and in-house training by qualified staff from both Office of Long-Term Care Standards Enforcement and Regional Health Administrators conducted on a regular basis.

Senator MAGNUSON. What additional training is needed, and what steps have been taken to obtain it?

Dr. COOPER. The Offices of Long-Term Care Standards Enforcement in the regions have been involved mainly in activities related to the

certification of skilled nursing facilities and general intermediate care facilities, and only recently have been able to assess their specific training needs in the area of intermediate care facilities for the mentally retarded. The Offices of Long-Term Care Standards Enforcement have received an adequate amount of training regarding the concepts and philosophy of mental retardation at this time. We believe additional training is needed in the actual implementation of the intermediate care facilities-mental retardation standards, with respect to the survey, certification and monitoring function of the Offices of Long-Term Care Standards Enforcement. A uniform training program for all regions is needed for the regional office staff responsible for monitoring the survey and certification process. Ways in which this training program can be implemented are currently being explored within budget limitations.

RELATIONSHIP OF PROJECTS TO DOMESTIC PROGRAMS

Senator MAGNUSON. Can you give me a few examples of how scientific activities overseas research projects relate to our domestic programs and how they help internationally?

Dr. COOPER. I would be pleased to do so. As you know, the Food and Drug Administration has responsibility for the protection of the American people by assuring the safety of drugs. To further this objective, FDA has supported studies in Yugoslavia on the effects of hormonal contraceptives on the outcome of pregnancy as well as the relationship between oral contraceptives and thromboembolism. Another area of major concern to FDA is food safety. In this connection, they are collaborating with a Moroccan institution on a study of the sanitary and environmental factors related to contamination of ground capsicum—primarily paprika and chili power—by rodent hairs, insect fragments, mold, and the like.

The National Cancer Institute is concerned with the development of therapeutic agents against cancer. Through a project funded by NCI in India, over 1,800 different plant materials have been collected, extracts made, and sent to the United States for examination. More than 80 plants were identified with confirmed activity against animal cancer.

In its continuing effort to find mechanisms to prevent and control communicable diseases, the Center for Disease Control has supported a number of studies in the excess currency countries which are directly applicable to domestic problems. These include a study of the epidemiology and control of streptococcal infection in Egypt and isoniazid prophylaxis trails against tuberculosis in Yugoslavia.

BUDGET INCREASE OVER 1975

Senator MAGNUSON. In 1975 I see you obligated $5.6 million, and in 1976 and 1977 you plan to obligate $13.1 million. Can you obligate these funds effectively, and why the big jump?

Dr. COOPER. We believe we can obligate these funds for scientific activities overseas effectively. Actually, during the period 1972 through 1975 we obligated less than we had planned for two reasons. First, our political relations with Egypt and India were uneven and, as a result,

we could not begin a number of very good projects which had been planned. Second, the supply of United States-owned currency in several countries diminished to the point that they were removed from the excess currency list. These countries were Israel, Morocco, and Yugoslavia.

Beginning in 1975, our relations with India and Egypt started to improve. This was evidenced by the establishment of Joint Cooperation Commissions with those two countries. Under the United States-Egypt Joint Cooperation Commission there is a Joint Working Group on Medical Cooperation of which I am cochairman with the Egyptian Minister of Health. As a direct result of the efforts of this group, some $12 million worth of projects are in various stages of development for possible funding during 1976 and 1977.

Although a separate medical working group has not been established under the United States-Indian Commission, health cooperation is being actively promoted through a Joint Science and Technology Working Group. We also expect to continue our very productive programs of cooperation with Poland, Pakistan, and Tunisia.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

Senator MAGNUSON. The increase in the number of retirees shown in your justification—is that a reflection of the normal trend of officers who are retiring, and how does it relate to past years?

Dr. COOPER. Yes, sir, it is a normal trend, however, there have been peaks in the last 5 years, such as when the earlier announcement was made indicating intent to close PHS hospitals. We are, during this decade, also having larger numbers of retirement eligibles as a result of the growth of the PHS during the 1940's and 1950's.

Senator MAGNUSON. The increase shown for Dependents' Medical Care of $3.4 million—is that primarily due to the patient load increase or is the cost of providing medical care going up?

Dr. COOPER. The increase of $3.4 million represents cost increase due to increased costs and also reflects an increase in the number of persons utilizing the services.

Senator MAGNUSON. Can we expect these costs to continue rising?

Dr. COOPER. Retirement benefits will continue to rise at approximately the same rate in future years. This growth rate is due to increases in the number of retirees, higher active duty salary pay for commissioned officers and cost of living increases. Dependents' medical care will continue to rise with the increases in workload as well as projected continued increases in medical care costs.

STATISTICS

Senator MAGNUSON. What is being done to coordinate the collection of health statistics throughout the Department so as to avoid duplication of effort by the requesters and suppliers of such data?

Dr. COOPER. Coordination of health statistics is extremely important in achieving the goals of providing good data while, at the same time, keeping burdens on those being surveyed to a minimum. In recognition of this, the Health Data Policy Committee was established in 1974 to develop policies and procedures to improve coordination in gather-

ing data. The Committee has developed into an effective vehicle for coordinating health statistics throughout HEW. Active participation from OMB, DOD, and the VA provides the Committee and the Department with valuable information on health data requirements and experience outside the Department. Through monthly meetings and several working subcommittees, the Committee addresses problems of coordination and duplication in specific data collection areas such as health manpower statistics and family planning data. In addition, for the first time, the Committee has sponsored the development of a health statistics plan that provides a comprehensive view of the entire health statistics system including an action plan for improving coordination of existing efforts and reducing reporting burdens by avoiding duplication in future efforts.

GRANTS MANAGEMENT

Senator MAGNUSON. What efforts have been made in the past 2 years to strengthen the management capability—financial and otherwise—of the various grantees who receive HEW funds for health services to help improve their chances of becoming self-supporting?

Dr. COOPER. The Health Services Funding Regulations, published approximately 2 years ago, formally reflect the great importance that we are placing on increasing the financial stability of the Public Health Service's health service delivery projects. The regulations stress the need for projects to develop the capability to recover third-party reimbursements and other revenue to the maximum extent possible so that Federal grant dollars will be used most productively. By strengthening the financial and administrative capability of the grantees that administer such projects, we are improving the chances that health services delivery projects can become self-supporting without sacrificing the quality of care. Although we have not accomplished as much as we would have liked to, we are making progress toward this goal of project self-sufficiency while at the same time insuring that we do not penalize those projects that are unable to develop additional funding sources. During the past 2 years some of the things we have done include providing financial management technical assistance to numerous health services delivery projects, developing technical support manuals on a variety of financial and administrative management subjects for distribution to projects, conducting financial management seminars with emphasis on assisting projects in becoming eligible for increased third-party payments, and effecting changes in the policies and practices of third-party payors.

FISCAL YEAR 1977 APPROPRIATION REQUEST

Senator MAGNUSON. What was the amount of funding your office requested for health from HEW for fiscal year 1977 compared to what you received? We would like to see a "Who Struck John" table on the fiscal year 1977 budget request.

Dr. COOPER. In the preliminary budget for the Public Health Service, as submitted to the Department, I had requested $5.7 billion for support of those programs under consideration by this committee. This compares with the amount of $4.4 billion within the President's budget for which I am appearing before you today. I will supply for the record a summary table giving the information on the Public Health Service's budget requests.

[The information follows:]

HISTORY OF FISCAL YEAR 1977 APPROPRIATION REQUEST

[Dollars in thousands]

	Estimate to department	Department estimate to OMB	1977 President's budget
Labor-HEW Committee:			
Health services	$1,135,850	$1,090,600	$697,187
Preventive health services	210,762	212,962	143,293
National Institutes of Health	2,257,105	2,188,385	2,165,047
Alcohol, drug abuse, and mental health	1,010,147	883,402	698,331
St. Elizabeths	58,234	58,234	57,963
Health resources	858,669	798,324	506,300
Payment of sales insufficiencies	4,000	4,000	4,000
Medical facilities guarantee and loan fund	31,000	31,000	31,000
Assistant Secretary for Health	26,493	26,493	22,216
Retired pay and medical benefits for commissioned officers	52,352	52,352	52,352
Scientific activities overseas	16,000	2,244	1,500
Total, Labor-HEW Committee	5,660,612	5,347,996	4,379,190

LAYERING EFFECT IN ADMINISTRATIVE OFFICE

Senator MAGNUSON. We are concerned about the layering effect in administrative offices (such as planning, budget, evaluation, personnel) throughout the Office of the Assistant Secretary for Health, the health agencies, and their programs. What input does each layer have after a document or proposal is prepared by a program?

Dr. COOPER. The administrative offices of the health agencies historically have provided a major oversight and review of program documents or proposals. This is necessary due to the diverse and geographically separated nature of programs within the Health agencies, and the need to administer resources supporting changing health priorities. Further, the staff of the Assistant Secretary for Health provides the necessary capacity for him to direct overall planning for the Public Health Service, to coordinate and review budget proposals, to weigh fiscal priorities, to direct the regional health administrators, to propose or approve the submission of health legislation, to direct international health efforts, and to oversee the overall implementation of health legislation and regulations.

After a proposal is prepared at the program level, input at the agency level includes consideration within overall agency priorities, review for technical correctness, consideration of potential alternatives, coordination with other interested agency offices, and finally decision by the agency director.

At my level, input includes coordination among the Health agencies, assuring that the proposal is consistent with my planning and budget priorities, assuring legislative input if necessary, preparation of options and alternatives if appropriate, and finally a decision on my part if it is a matter to be decided at the Assistant Secretary level.

I would point out that my staff has been instructed to minimize delay, and confusion to avoid impeding program operations. I believe we are succeeding to a significant extent.

Senator MAGNUSON. What efforts have you made to streamline this process?

Dr. COOPER. It is PHS policy to delegate authority and assign responsibility to the lowest practical level. Much of the activity of

offices within the Health agencies is not subject to further action by the Office of the Assistant Secretary for Health. We are engaged in continuing appraisal of organizational effectiveness and have modified a number of offices at both the Office of the Assistant Secretary for Health and the health agency levels. The objective is to emphasize policy decisionmaking and program oversight and overall coordination at the higher levels, and fix responsibility for implementing and reporting at the lower levels. Day to day management of operations takes place at the program level.

RURAL HEALTH INITIATIVE

Senator MAGNUSON. How many doctors do we need in rural areas to provide adequate health services to rural people? Could you provide us with the same information regarding dentists and nurses? Please show assumptions you use in arriving at your estimates.

Dr. COOPER. Given the current critical shortage areas designation criteria, there are approximately 1,400 areas now designated as critical health manpower shortage areas (CHMSA's); of these 950 are critical medical manpower shortage areas and 700 are critical dental areas (some areas are designated for both).

Staffing in general is designed to lower the physician to population ratio in these most critical areas from 1:4,000 or greater to 1:2,000 and the dentist ratio from 1:5,000 to 1:2,500. In order to provide adequate health services to rural people, given the current need, we would require about 2,850 doctors, 1,400 physician extenders, 1,000 dentists and 500 dental hygienists and auxiliaries. In addition, 8,500 personnel would be required to provide support for the medical providers. These could be hired locally.

By 1977–80, due to retirement, death, or resettlement of physicians currently practicing in rural areas, it is estimated that an additional 1,000 areas will be newly designated as CHMSA's. To provide services for these critical areas, an additional 3,000 doctors, 1,500 physician extenders, 1,000 dentists, and 500 dental hygienists and auxiliaries will be required.

Senator MAGNUSON. One of the concerns of the committee is that health workers that we do place in communities are assured of a good working situation, that they are fully employed, that the community is prepared for them, and that we otherwise create an environment which makes it attractive for the health workers to stay. Given the establishment of adequate criteria to assure that these factors are taken into account, how many health workers, by type, can we place in rural communities a year?

Dr. COOPER. The National Health Service Corps takes into account a variety of factors to insure an environment within which medical personnel can function effectively, efficiently, and with professional satisfaction. These factors generally fall into three categories: community support, structure of the practice, and specific personnel and professional needs of assignees.

Before a community is approved for NHSC assistance, it must demonstrate willingness to cooperate and provide a basic structure for the delivery of medical services. A "memorandum of agreement" establishes community commitments such as provision of facilities, adequate support staff, and implementation of an adequate record and

billing system. Professional management technique experts are made available to provide technical assistance when needed.

A major deterrent discouraging physicians from going to rural areas is professional isolation. The NHSC is pursuing policies stressing group practice or multiple provider sites, rather than solo practices. A major effort to bring this about is the Rural Health Initiative (RHI).

RHI sites generally cover a larger geographic area, combine resources of several PHS programs, (such as Community Health Centers, Migrant Health, and Appalachian Regional Commission) and can accommodate up to four or five or more medical providers. Not only does a group situation help alleviate professional isolation, but also it provides for more reasonable working hours and sharing the burden of 24-hour emergency coverage. Access to secondary and tertiary facilities is established also.

There are several areas in which policies can be pursued to accommodate personal and professional needs of assignees. Given the diverse characteristics of communities and potential medical providers, the matching process has been revised to meet critical needs. Orientation conferences are conducted for providers and their spouses. Technical assistance is offered to develop good patient management techniques. Professional isolation is diminished through emphasizing multiple-provider site structure and establishing linkages with other group practices through efforts of the American Group Practice Association.

Right now, we are able to recruit 200 to 300 physicians annually. In addition we are incorporating National Health Service scholarship recipients into the NHSC. There will be about 200 recipients available in 1977 and the number will increase in out years according to the funding levels appropriated for the scholarship program. We are also recruiting about 100 to 200 dentists and physician extenders per year.

Senator MAGNUSON. How many physicians, dentists, and other health workers can be recruited a year for service in rural areas?

Dr. COOPER. Currently we are recruiting about 200 to 300 physicians, 100 to 200 physician extenders, and 100 to 200 dentists annually. In 1977, we will have access to about an additional 200 physicians who will be fulfilling service obligations incurred as Public Health Service/National Health Service Corps Scholarship recipients. The numbers of dentists and physician extenders is essentially limited only by the number of sites we can develop to accommodate them.

ATTRACTING HEALTH WORKERS TO RURAL AREAS

Senator MAGNUSON. There has been some discussion about the best and most economical way of attracting health workers, particularly physicians, to rural areas. The National Health Service Corps program including scholarship and placement, is one. Do you feel that the level of support for scholarship is set at the right level considering both economy and the need to make the program attractive to medical students? A number of critics have stated that the scholarship level is set too high, and that an adequate number of medical students could be attracted if the scholarship amounts were set lower. Could you comment on that?

Dr. COOPER. The NHSC has proven a very cost-effective way of placing health workers in critical health manpower shortage areas. The total program cost per field assignee is about $38,000 per year. This includes salary and bonus, supplies, equipment, travel requirements, continuing medical education, permanent change of station, and technical assistance costs for site development.

At the present time, the stipend level for the DHEW scholarship program, to students who later serve in the NHSC, is $6,750 a year plus tuition and fees, averaging $3,250 per student. This is a total average scholarship cost of $10,000 per student. This level was chosen to reflect a level of parity with the armed services physician scholarships programs.

At the $6,750 stipend level a student need not take out additional educational loans. On the other hand, most students awarded scholarships under the DHEW program are in their junior year and have already incurred debts to finance their education. Under the DHEW scholarship program these students can neither receive benefits under the loan repayment program nor receive variable incentive pay.

It is possible the students might apply for scholarships at lower levels. However, we must consider competing programs, the tradeoffs already required of students, and the possible adverse effect this might have on the number and quality of students who would be available in the applicant pool.

STEPS BY FEDERAL GOVERNMENT IN ATTRACTING HEALTH WORKERS

Senator MAGNUSON. Are there other steps which the Federal Government can take and which can be supported through existing legislation which can put health workers into underserved rural areas?

Dr. COOPER. In addition to the DHEW scholarship program there are a variety of steps which we are taking to encourage placement of medical professionals in underserved rural areas.

The new rural health initiative (RHI) of the Bureau of Community Health Services is an even more promising mechanism for attracting and retaining physicians and other health workers in underserved rural areas because it combines the specialized services of several programs in a unified effort to address obstacles encountered in serving various population groups and underserved areas. In implementing the RHI, we have identified areas throughout the country which are in accord with the statutory requirements of the varying programs of BCHS. The RHI links together not only BCHS programs, but also those of the PHS as a whole to develop rural health delivery systems in areas of greatest need, as characterized by low population density; high proportions of elderly, poor, or undereducated people; poor transportation; and low physician/patient ratios. The NHSC provides manpower recruitment and placement services; the community health centers and the migrant health programs provide focus for medical and supportive services. By placement of rural health initiatives sites where they might serve or be linked with other providers serving migrant workers, all these programs are brought together to form a closer, more productive, and lasting health services component in rural areas. We need to continue the rural health initiative sites we have begun and to expand this approach to include other programs such as family planning and the maternal and child health activities.

We are in the process of establishing a clearinghouse to expand our ability to match all interested medical professionals, including non-Federal physicians, to rural areas where they would be most likely to set up and continue in practice.

FEDERAL EFFORTS TO IMPROVE RURAL HEALTH SERVICES

Senator MAGNUSON. Could you describe other Federal efforts to improve the quality and quantity of rural health services?

Dr. COOPER. One of the primary objectives of the Bureau of Community Health Services is the continuing improvement of the capacity of its programs to deliver high-quality health care services at reasonable costs.

Efforts to improve quality of care in Bureau programs have followed several lines. Ambulatory health care standards have been developed and tested in the community health centers program. We plan on their implementation in all Bureau programs. In a related effort there is an activity underway to define specific standards for nutrition, prenatal care, well-baby examinations, immunizations, and related clinical areas which have broad application throughout Bureau programs. Through the development of an internal medical audit manual, mechanisms are provided for centers to generate periodic reports on the quality of medical care provided as reflected in the medical records. This provides the means for project managers to maintain real control on the quality of care which they deliver. Additionally, those internal medical audit activities are periodically confirmed and complemented through external reviews by an evaluation team.

The ambulatory standards, along with the program of internal and external quality of care audits and the development of project specific action plans responsive to audit findings, have enabled the centers to develop and maintain a high level of service quality in spite of expanding patient load. Also, it is planned that all programs and projects within the Bureau of Community Health Services become participants in local professional standard review organization activities.

The NHSC specifically pursues policies to assess and improve quality of health services delivery such as providing for the problem-oriented medical record, increasing emphasis on comprehensive care through greater integration of dental services at sites, stressing patients' role in preventive medicine, and implementing organized approaches to patient and practice management systems. Continuing medical education services include provision of $500 per assignee for training, provision of audio-visual capabilities to all medical sites, establishing linkages with other medical providers, and arranging for professional meetings on State and regional bases.

EDUCATIONAL AND PROFESSIONAL SUPPORT FOR RURAL PHYSICIANS

Senator MAGNUSON. One of the most frequently discussed factors regarding the unattractiveness of medical practice in rural areas is professional isolation. We are very interested in the steps that the Department might take to deal with this problem. For example, medical schools could serve this function. Frequently, however, our arrangements with medical schools turn out to be extraordinarily expensive. Has thought been given to what the Federal Government might pay for such support, if anything? Has thought been given to making such

involvement a condition which States must meet before placing of health workers in communities? Have alternatives for providing such support been considered such as associations with existing group practices or hospitals with full-time medical staffs?

Dr. COOPER. At the present time, there are few formal or institutional resources for educational or professional support for rural physicians. We are encouraging within medical centers a commitment to continuing education programs for physicians and a willingness to be involved with the postgraduate needs of the practitioner. We also need to set up a network of centers easily accessible to rural physicians to consult with other physicians and refer patients for specialty medical care.

The NHSC, for its part, in conjunction with the Bureau of Health Manpower in the Health Resources Administration, is currently identifying and utilizing physicians within medical schools and other training centers as coordinators of continuing education for physicians in clusters of rural sites, initially involving 40 to 50 sites. These coordinators will visit the physician in his practice setting and work with him to plan and put into effect a specific educational program designed to meet his needs.

The American Group Practice Association is currently under contract to the NHSC to explore ways of linking other providers, such as group practices, with 55 NHSC sites. A similar contract with the Stokes Phelps Foundation aims at building similar linkages for 15 to 20 sites in the Southeast.

Another approach we are exploring involves setting up a system and identifying physicians who can provide coverage to NHSC physicians so that the corps physicians can pursue educational activities away from the site at certain regular intervals, through contracts with the AMA and the American Association of Osteopathic Colleges.

The NHSC is also attempting to work with the Area Health Education Centers (AHEC's) located in 11 States serving different regions of the country to bolster their effort to provide continuing education for isolated medical practitioners.

In addition to these endeavors to build relationships to resources outside the site area, the NHSC is making strong efforts to involve each local medical community in the developmental and operational phases of site development.

Another important measure to mitigate professional isolation is the assignment of health professionals in groups or teams, wherever possible especially as part of the Bureau's Rural Health Initiative. We need to pursue this approach in an increasingly larger context to develop networks of small practices lined to a central hospital and multispecialty group.

Finally, the NHSC has put particular attention to the development of educational resources to be used by the rural practitioner in his office or home, including a telephone access system to audiotapes on various clinical problems now available on an 800 line for all NHSC professionals, audiovisual programs on specific clinical topics among the sites, and videotape equipment and computer assisted educational programs, now being tested.

Senator MAGNUSON. Thank you, Dr. Cooper, for your fine presentation. The subcommittee will take your requests under consideration.

Dr. COOPER. Thank you, Mr. Chairman.

RETIREMENT PAY AND MEDICAL BENEFITS FOR COMMISSIONED OFFICERS

STATEMENT OF LEE SMITH, DIRECTOR, OFFICE OF PERSONNEL MANAGEMENT, OFFICE OF ADMINISTRATIVE MANAGEMENT, PUBLIC HEALTH SERVICE

ACCOMPANIED BY:

MORTON SMALL, CHIEF, FINANCIAL MANAGEMENT BRANCH, BUREAU OF MEDICAL SERVICES

CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER

BIOGRAPHICAL SKETCH

Senator MAGNUSON. We will now hear from Mr. Lee Smith, Director, Office of Personnel Management, Office of Administrative Management of the Public Health Service. He will be discussing the fiscal year 1977 budget request for the "Retirement Pay and Medical Benefits for Commissioned Officers."

We will place your biographical sketch in the record at this point, Mr. Smith, after which you may present your statement.

Mr. SMITH. Thank you, Mr. Chairman.

[The biographical sketch follows:]

BIOGRAPHICAL SKETCH

Name: Lee W. Smith.

Position: Assistant Surgeon General (0-7), PHS Commissioned Corps, Director, Office of Personnel Management, Office of Administrative Management, Public Health Service.

Birthplace: Pittsburgh, Pennsylvania.

Birthplace and date: Pittsburgh, Pennsylvania February 13, 1928.

Education: 1952 B.S., University of Pittsburgh; 1952 M.S., University of Pittsburgh; 1958 M.P.H., University of Pittsburgh; 1968 Management Course, American Management Association Graduate Biochemistry, Genetics and Microbiology Courses, George Washington University School of Medicine.

Military: 1945–49 U.S. Navy, PhM 2/C Laboratory Technician.

Experience: 1973, present, Director, Office of Personnel Management, OAM/PHS.

1971–73, Director, Commissioned Personnel Division, OPT/OS.

1963–71, Executive Assistant to the Deputy Assistant Secretary for Personnel and Training, OPT/OS.

1968, Director, Division of Operations and Services, OP/PHS.

1967–68, Special Assistant to the Deputy Surgeon General, PHS.

1965–67, Chief, Personnel Utilization Branch, OP/PHS.

1961–65, Placement Officer, Bureau of Medical Services and Deputy Chief, Personnel Utilization Branch, OP/PHS.

1959–61, Research Associate, National Institute of Allergy and Infectious Diseases, NIH.

1958–59, Research Fellow, National Institutes of Health, Department of Epidemiology and Microbiology.

1955–57, Laboratory Director, Encephalitis Investigations Unit, Center for Disease Control, PHS.

1953–55, Research Associate, Graduate School of Public Health, University of Pittsburgh.

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Memberships: American Public Health Association; American Society of Microbiology; Phi Sigma Society; Sigma Xi; Delta Sigma Phi; Commissioned Officers Association—PHS; Various Masonic Bodies.

Awards: Phi Sigma and Sigma Xi; Exceptional Capability Promotion, 1966; PHS Meritorious Service Medal, 1969.

BUDGET REQUEST

Mr. SMITH. Mr. Chairman and members of the committee: I am pleased to appear before you today to discuss the 1977 budget request for Retirement Pay and Medical Benefits for Commissioned Officers and Dependents. This appropriation authorizes such amounts as may be necessary for mandatory payments made under two separate programs.

PAYMENTS TO RETIRED OFFICERS AND SURVIVORS

The first program covers payments to retired officers of the Public Health Service and to survivors of deceased retired officers. Benefits to retired officers are authorized by section 211 of the Public Health Service Act, while those to survivors are authorized by the Retired Serviceman's Family Protection Plan and the Survivors Benefit Plan enacted in 1972. The request for $27.6 million for fiscal year 1977, an increase of $3.9 million is based on the number of present beneficiaries now being paid adjusted by the anticipated additions and terminations. The number of retired officers as of June 30, 1975, is 1,375. This number is expected to be 1,479 on September 30, 1976, and is projected to increase to 1,568 by September 30, 1977.

These additional beneficiaries, 89 additional retired officers, and 11 additional survivors, combined with anticipated cost of living increases require an additional $3.9 million.

DEPENDENTS' MEDICAL CARE

The Dependents' Medical Care Act and the Military Medical Benefits Amendments of 1966 authorize the provision of medical care to active duty and retired uniformed service personnel, their dependents, and dependents of deceased servicemen of the Coast Guard, the National Oceanic and Atmospheric Administration and the Public Health Service. Expenses of the dependents' medical care program are for contract medical care furnished to dependents and retirees. The cost in Federal facilities are for inpatient care. Contract care costs in non-Federal facilities provide inpatient care, outpatient care, and rehabilitative care for physically handicapped and mentally retarded dependents.

The budget request for $24.8 million in 1977 represents an increase of approximately $3.4 million. This total amount will provide care for an estimated daily patient care load of 352 persons, 27,900 annual outpatient visits and care of 184 handicapped dependents. The increase requested in this account is necessitated by increased workloads as well as rising medical costs.

SUMMARY

In summary then, the fiscal year 1977 budget request is $52.4 million to provide $27.6 million for retired pay for commissioned officers and

their survivors and $24.8 million for the dependents' medical care program.

JUSTIFICATION

That concludes my statement, Mr. Chairman. I would like at this time to have placed in the record the justification material for this item.

Senator MAGNUSON. Thank you, very much, Mr. Smith. We appreciate your appearance today before the subcommittee.

The justification material will be placed in the record at this point.

[The justification follows:]

Justification

Appropriation Estimate

Retirement Pay and Medical Benefits for Commissioned Officers

For retired pay of Commissioned Officers, as authorized by law, and for payments under the Retired Serviceman's Family Protection Plan; Survivor Benefit Plan and payments for medical care of dependents and retired personnel under the Dependents' Medical Care Act (10 U.S.C., ch. 55), such amount as may be required during the current fiscal year.

Amounts Available for Obligation

	1976	1977
Appropriation (Indefinite)	$45,013,000	$52,352,000

Summary of Changes

1976 Estimated Obligations	$45,013,000
1977 Estimated Obligations	52,352,000
Net change	7,339,000

	1976 Base Amount	Change from Base Amount
Increases:		
A. Built-in:		
1. Annualization of retirements during 1976 and the transition quarter and 89 additional retirements during 1977	$23,067,000	+$3,781,000
2. Net increase of 15 survivors receiving benefits	600,000	+117,000
3. Cost of increased inpatient and outpatient care for retirees and dependents	19,894,000	+3,236,000
4. Increase for ancillary services (drugs, handicapped care, contractors' fees, etc.) required by an expanding beneficiary population	1,452,000	+205,000
Total increases		+7,339,000

Obligations by Activity

	1976 Appropriation Amount	1977 Estimate Amount	Increase or Decrease Amount
Retirement payments.....	$23,067,000	$26,848,000	+$3,781,000
Survivors' benefits.....	600,000	717,000	+117,000
Dependents' medical care.....	21,346,000	24,787,000	+3,441,000
Total obligations.....	45,013,000	52,352,000	+7,339,000

Obligations by Object

	1976 Appropriation Amount	1977 Estimate Amount	Increase or Decrease Amount
Benefits for former personnel....	$23,667,000	$27,565,000	+$3,898,000
Other services.....	21,346,000	24,787,000	+3,441,000
Total obligations by object....	45,013,000	52,352,000	+7,339,000

Year	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1967	$8,977,000	$8,977,000	$8,977,000	$10,837,719
1968	13,391,000	13,391,000	13,391,000	11,290,000
1969	15,090,000	15,090,000	15,090,000	14,265,000
1970	16,700,000	16,700,000	16,700,000	16,567,000
1971	19,501,000	19,501,000	19,501,000	21,349,000
1972	23,196,000	23,196,000	23,196,000	23,960,000
1973	29,163,000	29,163,000	29,163,000	28,106,000
1974	34,103,000	34,103,000	34,103,000	34,524,000
1975	43,422,000	43,422,000	43,422,000	39,499,000
1976	45,013,000	45,013,000	45,013,000	
1977	52,352,000			

1977 Congressional Justification

ASSISTANT SECRETARY FOR HEALTH

Retirement Pay and Medical Benefits for Commissioned Officers

	1976 Appropriation Amount	1977 Estimate Amount	Increase or Decrease Amount
Retirement payments.....	$23,067,000	$26,848,000	$3,781,000
Survivors' benefits.....	600,000	717,000	117,000
Dependents' medical care.....	21,346,000	24,787,000	3,441,000
Total obligations.....	45,013,000	52,352,000	7,339,000

General Statement

This appropriation provides for retirement payments to Public Health Service officers who are retired for age, disability, or length of service as well as payments to survivors of deceased retired officers who had received reduced retirement payments.

Provision is also made for the cost of medical care provided in non-Public Health Service facilities to dependents of Public Health Service beneficiary members of the uniformed services and retired personnel.

Retirement Payments

	1976 Appropriation Amount	1977 Estimate Amount	Increase or Decrease Amount
Other expenses.....	$23,067,000	$26,848,000	$3,781,000

This estimate provides for mandatory payments for officers retired for age, length of service, or disability.

Impact of the 1977 Budget:

- The estimate is based on payments to the following number of retirees:

Period Ending	Total
June 30, 1975	1,375
June 30, 1976	1,458
Sept. 30, 1976	1,479
Sept. 30, 1977	1,568

Survivors' Benefits

	1976 Appropriation Amount	1977 Estimate Amount	Increase or Decrease Amount
Other expenses.....	$600,000	$717,000	$117,000

This activity provides for the payment of annuities to survivors of retired officers who elected to receive reduced retirement payments under the Retired Serviceman's Family Protection Plan; Survivor Benefit Plan.

Impact of 1977 Budget:

- The estimate is based on payments to the following numbers of annuitants.

Period Ending	Total
June 30, 1975	112
June 30, 1976 (Est.)	124
Sept. 30, 1976 (Est.)	128
Sept. 30, 1977 (Est.)	139

Dependents' Medical Care

	1976 Appropriation Amount	1977 Estimate Amount	Increase or Decrease Amount
Other expenses.....	$21,346,000	$24,787,000	$3,441,000

This program provides for the cost of medical care rendered outside the Public Health Service, both in non-Federal and in uniformed service facilities, to dependents of eligible personnel of the United States Coast Guard, the National Oceanic and Atmospheric Administration and the Public Health Service, and to retired personnel of these services.

Impact of 1977 Budget:

- The estimate is based upon the following workloads:

Period	Average Daily Patient Load	Outpatient Claims	Handicapped Care Recipients
1975	326	26,000	175
1976 (Est.)	335	26,900	175
Transition Quarter (Est.)	352	8,700	178
1977 (Est.)	352	27,900	184

Program Purpose and Accomplishments

Activity: Retirement Pay (Public Health Service Act as amended, Sec. 211; 10 U.S.C., 1201)

1976 Appropriation Amount	1977 Authorization	1977 Budget Estimate Amount
$23,067,000	Indefinite	$26,848,000

Purpose: This authority provides for payments to Commissioned Officers of the Public Health Service who have been retired for age, disability or specified period of service.

Explanation: Public Health Service officers do not contribute to the retirement fund. The fund is supported by the Federal Government through an annual appropriation.

Accomplishments: An estimated 83 retirees in 1976 and 21 retirees in the Transition Quarter will be added to the retirement roll, resulting in a total of 1,458 retirees as of June 30, 1976 and 1,479 as of September 30, 1976.

Objective for 1977: A net increase of 89 officers will result in an estimated total of 1,568 retired officers at the end of fiscal year 1977.

Activity: Survivors' Benefits (10 U.S.C., ch. 73)

1976 Appropriation Amount	1977 Authorization	1977 Budget Estimate Amount
$600,000	Indefinite	$717,000

Purpose: Under the provisions of the Retired Serviceman's Family Protection Plan; Survivor Benefit Plan, retired personnel who elect to receive reduced amounts of retirement pay are able to provide for monthly payments to be continued to their survivors.

Explanation: This program is financed by the Federal Government although deductions are made in the retirement payments to the officers who elect the option of survivors' benefits.

Accomplishments: It is estimated that there will be a total of 124 annuitants as of June 30, 1976 and 128 by September 30, 1976.

Objectives for 1977: It is estimated that there will be a total of 139 annuitants on the rolls at the end of fiscal year 1977.

Activity: Dependents' medical care (10 U.S.C., ch.55)

1976 Appropriation Amount	1977 Authorization	1977 Budget Estimate Amount
$21,346,000	Indefinite	$24,787,000

Purpose: The Dependents' Medical Care Act, as amended by P.L. 89-614, provides for an expanded and uniform program of medical care to active duty and retired members of the uniformed services and dependents of active duty, retired and deceased members.

Explanation: This activity is used to satisfy the mandatory obligations of the Public Health Service. They arise because a dependent or a retired person receives care in an approved medical facility. The amount of the expense varies, depending on the medical facility that the Public Health Service beneficiary enters: (1) if care is given in a Public Health Service facility, there is no charge under the Dependents' Medical Care Act, (these costs are chargeable to the appropriation, Health Services); (2) if care is given in the facility of another uniformed service, the Public Health Service is billed directly by that organization; and (3) if medical care is given in a private facility, a contractor, such as Blue Cross, pays the hospital and bills the executive agent in the Department of Defense, who in turn bills the Public Health Service for the services rendered.

Accomplishments: It is estimated that in 1976 a daily average of 335 persons will be hospitalized, 76,900 total outpatient claims will be processed and 175 beneficiaries will receive care under the handicapped care provision of the Dependents' Medical Care Act. The workload for the Transition Quarter is estimated to be 3% greater than the same three months in 1976.

Objectives in 1977: The estimated number of eligible beneficiaries in 1977 will be 3.6% greater than that of 1976. The level of funding requested will allow delivery of health care to this larger beneficiary population. Currently, there are anticipated in non-Public Health Service facilities an average daily inpatient load of 352, total outpatient claims of 27,900 and 184 handicapped care cases.

Transition Quarter Analysis

	Budget Authority by Activity: 1976 Appropriation	Transition Quarter
1. Retirement Pay	$23,067,000	$7,019,000
2. Survivors' Benefits	600,000	149,000
3. Dependents' Medical Care	21,346,000	6,384,000
Total	45,013,000	13,552,000

Explanation

Funds are required for the transition quarter to provide for the mandatory obligations of this program of the Public Health Service. These obligations include the annualization of 1976 retirements and annuities plus 21 additional retirees and 4 additional annuitants expected to come on the rolls as well as three months non-Public Health Service medical care costs for the estimated beneficiary population of 166,800.

SUBCOMMITTEE RECESS

Senator MAGNUSON. That concludes the proceedings for today. The subcommittee will stand in recess, subject to the call of the Chair.

(Whereupon, at 3:30 p.m., Friday, January 30, 1976, the subcommittee was recessed, to reconvene at the call of the Chair.)

DEPARTMENTS OF LABOR AND HEALTH, EDUCATION, AND WELFARE AND RELATED AGENCIES APPROPRIATIONS FOR FISCAL YEAR 1977

MONDAY, FEBRUARY 2, 1976

U.S. SENATE,
SUBCOMMITTEE OF THE COMMITTEE ON APPROPRIATIONS,
Washington, D.C.

The subcommittee met at 2 p.m., in room S–128, the Capitol, Hon. Warren G. Magnuson (chairman) presiding.

Present: Senator Magnuson.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE

HEALTH SERVICES ADMINISTRATION

STATEMENT OF DR. JOHN E. MARSHALL, ASSOCIATE ADMINISTRATOR FOR OPERATIONS

ACCOMPANIED BY:

DR. EDWARD D. MARTIN, DIRECTOR, BUREAU OF COMMUNITY HEALTH SERVICES

W. HARELL LITTLE, DIRECTOR, OFFICE OF FINANCIAL MANAGEMENT, HEALTH SERVICES ADMINISTRATION

CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER

OPENING REMARKS BY CHAIRMAN

Senator MAGNUSON. This afternoon we will begin our hearings with Dr. John E. Marshall of the Health Services Administration.

The programs contained within this account are of growing importance to this country while we continue to place more emphasis upon health services delivery. Further, as we begin our preparation for possible enactment of national health insurance many of these programs will be a vital link in a comprehensive health system chain.

Your budget proposes the complete closing down of health grants to States or minus $90 million. There are also proposals to phase down, by as much as 20 to 40 percent, such important programs as maternal and child health, migrant health and community health centers.

We will be interested in hearing your justification for these drastic cuts.

BIOGRAPHICAL SKETCH

Dr. Marshall, we will place your biographical sketch in the record at this point, after which you may proceed with your statement.

[The biographical sketch follows:]

BIOGRAPHICAL SKETCH

Name : John E. Marshall, Ph.D.

Position : Associate Administrator for Operations, Health Services Administration

Birthplace and Date : Hazleton, Pennsylvania
August 6, 1935

Education : 1957 A.B., Muhlenberg College, Allentown, Pennsylvania
1959 M.A., Temple University, Philadelphia, Pennsylvania
1963 Ph.D., Temple University

Experience:

9/1974 - Present	Associate Administrator for Operations Health Services Administration, OA
10/1973 - 9/1974	Deputy Director, Bureau of Community Health Services, HSA
11/1971 - 9/1973	Assistant Director for Program Development National Center for Health Services Research and Development, HSMHA
10/1970 - 5/1971	Director, Office of Research Training National Center for Health Services Research and Development, HSMHA
7/1970 - 10/1970	Staff, Office of Research Training National Center for Health Services Research and Development, HSMHA
1969 - 1970	Grants Associate, National Institutes of Health
1967 - 1969	Assistant Professor, Psychology Department, Rensselaer Polytechnic Institute Troy, New York
1960 - 1967	Commissioned Officer, U. S. Army Medical Service Corps
	Clinical Internship, Walter Reed Army Medical Center
	Instructor, Department of Neuropsychiatry Ft. Sam Houston, Texas

	Research Psychologist, Experimental Psychology Division, U. S. Army Medical Research Laboratory Ft. Knox, Kentucky
1958 - 1960	Instructor, Department of Psychology, Temple University
1957 - 1958	Graduate Assistant, Department of Psychology Temple University

Memberships: American Psychological Association
Eastern Psychological Association
Midwestern Psychological Association
American Association for the Advancement of Science

Awards : Cardinal Key Society, service
Pi Delta Epsilon, national journalism
Alpha Kappa Alpha, national philosophy

Scientific Papers :

An experimental analysis of the relationship between eye movements and the autokinetic phenomenon. Division 3, Americal Psychological Association, September 1963.

Visual cues and angular acceleration threshold. Midwestern Psychological Association, May 1965.

A specific condition in which vision does influence nystagmic habituation, Eastern Psychological Association, April 1966.

Drug control of arousal and nystagmic habituation in cat. Co-author with J. H. Brown, Psychonomic Society, October 1966, paper read by Dr. Brown.

Generalization of nystagmic habituation as a function of stimulus intensity. Co-author with J. H. Brown, Eastern Psychological Association, April 1967, paper by Dr. Marshall.

Family dynamics and homosexuality. Co-author with J. R. Snortum, J. R. Gillespie, J. P. McLaughlin and L. Mosbert. Western Psychological Association, March 1968, paper read by Dr. Snortum.

Vestibular habituation: A specific or generalized response decrement? Co-author with J. H. Brown and V. J. Pribyl, Southern Society for Philosophy and Psychology, April 1968, paper read by Dr. Brown.

Actinomycin D impairs retention of impriting in chicks. Co-author with S. D. Codish, Eastern Psychological Association, April 1968, paper read by Codish.

Publications: Eye Movements and the Visual Autokinetic Phenomenon. Perceptual and Motor Skills, 1966, 22, 319-326.

Marshall, J. E. and Brown, J. H. Visual-Arousal Interaction and Specificity of Nystagmic Habituation. Aerospace Medicine, 1967, 38, 597-599.

Brown, J. H. and Marshall, J. E. Drug Control of Arousal and Nystagmic Habituation in Cat. Acta Otolaryngologica (Stockholm, Sweden), 1967, 64, 345-352.

Visual Cues and Agnular Acceleration Threshold. U. S. Army Medical Research Laboratory Research Report No. 745, 1967.

Snortum, J. R. Gillespie, J. F., Marshall, J. E., McLaughlin, J. P. and Mosberg, L. Family Dynamics and Homosexuality. Psychological Reports, 1969, 24, 763-770.

Health Services Data Systems. Hospital Topics, March 1973, 51, 23-25.

STATEMENT OF DR. JOHN E. MARSHALL

Senator MAGNUSON. Dr. Marshall, you may proceed with your statement.

Dr. MARSHALL. Mr. Chairman and members of the committee, I appreciate this opportunity to discuss with you the programs of the Health Services Administration and the budget request for fiscal year 1977. The Health Services Administration is comprised of four major organizations: the Bureau of Community Health Services, the Bureau of Quality Assurance, the Bureau of Medical Services, and the Indian Health Service. Because the appropriation request for the Indian Health Service is considered by the Interior Subcommittee, this testimony addresses only the programs of the first three Bureaus.

HSA PROGRAMS AND GOALS

The programs of the Health Services Administration promote the accessibility, efficiency, and quality of health care services delivered to broad segments of the population of the United States. These goals are achieved first by providing leadership in innovative health service delivery programs operated directly by the Health Services Administration or funded through formula or project grant mechanisms and secondly by administering programs designed to improve the organization, effectiveness, and quality of care of health services delivery. In pursuit of these goals, the Health Services Administration has organized its program efforts around four strategic roles. These are: (1) to place appropriate health personnel in underserved areas, that is, to build primary health care capacity; (2) to maintain such capacity, especially in circumstances where it cannot become self-sustaining; (3) to improve the organization and efficiency of health care delievery; and (4) to assure the quality of federally financed health services.

The National Health Service Corps represents the Department's major focus of effort for the building of health services capacity in areas having critical shortages of the manpower required to deliver health care. During the early years of the National Health Service Corps program, major efforts were required to build up a manpower resource capacity to provide staff for communities with critical health manpower shortages. Having established a relatively stable and effective recruitment system, we are now better able to redirect more effort and resources to the more fundamental goals of assisting communities in developing the capacity to independently maintain viable health practices, and developing policies that will encourage health professionals, once placed, to remain on a non-Federal basis. In 1977, we project 150 sites will have become independent, serving approximately 450,000 people, which is in addition to 820,500 people served by NHSC assignees. In 1977, the retention rate is expected to increase to 40 percent, which will mean that of the assignees completing their 2 year contract period, about 100 will be either extending for a third year or will be staying in the communities as private citizens. The budget request for this program includes $24,529,000 and 676 positions, an increase of $7,000,000 and 125 positions over the 1976 level.

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HEALTH SERVICE DELIVERY CAPACITY PROGRAMS

The programs with the principal mission of maintaining health service delivery capacity in health scarcity areas include the community health centers, material and child health, family planning and migrant health projects. These programs will provide services to approximately 13 million people in 1976. Program management improvements have increased the number of people served and the quality of service provided by these programs. For example, during 1976 the community health center reimbursement level will increase from 20 percent to 22 percent and the primary physician encounter rate will increase from 2.5 to 2.7 encounters per hour. During 1976, the application of health care standards for all of these programs will be implemented. Special attention, consistent with the new health services legislation, will be initiated. For example, dollars will be targeted to high impact migrant areas and to programs for teenagers in need of family planning services.

BUDGET REQUEST FOR FISCAL YEAR 1977

The 1977 budget for these programs requests the same dollar level as in the President's original 1976 budget. This estimate will assure program continuity while action is being taken on the proposed legislation for a health block grant.

In addition to these grant programs, the Health Services Administration has maintained services capacity through the direct provision of health care to certain statutory beneficiaries. The 1977 budget proposes to revise the principal method of providing inpatient care to these Public Health Service general hospitals by transferring to community use or closing the eight Public Health Service hospitals. Primary beneficiaries would instead receive inpatient care in community facilities on a contractual basis with the Public Health Service. Outpatient care will continue to be provided through Public Health Service clinics.

ESTABLISHMENT AND GROWTH OF HEALTH MAINTENANCE ORGANIZATIONS

The Health Services Administration will continue efforts to improve the organization and efficiency of health care delivery by fostering the establishment and growth of health maintenance organizations as an alternative to existing health care delivery mechanisms. During fiscal year 1977, we expect to fund 24 planning and 15 development grants. These grants, in addition to projects previously funded plus the 14 loans for initial operations, will eventually generate 50 HMO's which, at maturity, will have a potential of serving 1,500,000 enrollees. Program emphasis will be placed upon technical assistance to potential health maintenance organizations and guidance in the implementation of the HMO Act.

EMERGENCY MEDICAL SERVICES PROGRAM

A second important effort to improve the organization of health care delivery is the Emergency Medical Services program. This pro-

gram provides assistance in establishing systems for the delivery of emergency medical services that enhance patient survival and care from an initial incident, on through definitive care. Such systems involve 15 well-defined components integrated to maximize the utilization of all care resources with a specified geographical area. Although the program is too new to have accumulated data to show its effects on a nationwide basis, significant data are available from several communities showing the saving of lives.

Each State and territory has now established an organization to be responsible for emergency medical services activities. It is anticipated that, on a cumulative basis, funding will have been provided to support 120 emergency medical services systems in some form of operation with a potential impact on 60 million persons.

PSRO PROGRAM

The PSRO program is one of the most significant quality assurance activities now being implemented throughout the country. It represents a unique opportunity to improve the quality and utilization of medical care services and should result in effective controls on health expenditures.

PSRO's are organizations of physicians who apply systematic peer review methods to determine the necessity, appropriateness and quality of medical care finanaced by the medicare, medicaid and maternal and child health programs. Prior to the enactment of the PSRO statute in 1972, this authority rested with the medicare intermediaries and the medicaid State agencies rather than with physician organizations. There are now 106,000 physicians who are members of the existing 120 PSRO's. This represents about one-half of the physicians in these areas. Early impact data from those PSRO's which have been PSRO hospital review consistently results in reduction in lengths of stay and some reductions is unnecessary hospital admissions and services. We have available, and will provide, additional information on the impact of PSRO review.

There are now 65 conditional PSRO's which will review approximately 1,900,000 medicare and medicaid admissions in over 1,700 hospitals during fiscal years 1976. About 80 percent of these conditional PSRO's have begun review since last July when they were designated or conditional PSRO's. We have 55 planning PSRO's. Many of these planning PSRO's are already qualified for conditional designation and we expect that all of these will be qualified for conditional designation within the next 6 months.

The budget request of $62 million includes a $14,418,000 increase over the 1976 level. This increase will allow the PSRO program to cover all 203 PSRO areas throughout the country. Eventually this will permit full replacement of the duplicate, Federally required hospital utilization review system now in existence in about all of the Nation's 7,000 hospitals. This request will permit the continuation of 65 conditional PSRO's, the conversion of 55 PSRO's from planning to conditional and the funding of 83 new PSRO's.

SUMMARY

In summary, Mr. Chairman, the Health Services Administration will continue its efforts to improve the distribution of health resources, to monitor the quality of health care delivery, and to reduce the rise in health care costs.

That concludes my statement, Mr. Chairman. I will answer any questions you may have.

HEALTH SERVICES FUNDING LEVELS

Senator MAGNUSON. You are proposing drastic cutbacks for just about every health service agency. Do you really think this is sound rationale in light of the inability of the States to pick up these costs?

Dr. MARSHALL. The President believes that a greater share of the costs of these programs should be a State and local responsibility. He is proposing these levels pending congressional consideration of the health block grant proposal.

Senator MAGNUSON. What will happen to the patients?

Dr. MARSHALL. There should be no reduction in the number of people served if the priorities are so determined and responsibility assumed at the State and local levels. If this does not occur, a certain number of patients will not have access to these services.

COMPREHENSIVE PUBLIC HEALTH GRANTS TO STATES

Senator MAGNUSON. You are proposing to completely wipe out the comprehensive health grants to States program—a reduction of over $90 million.

What will happen to those health programs in the States which depend on this money?

Dr. MARSHALL. This program funds an average of 4 percent of State health costs. Not all of these costs are in the direct services category. The State programs would be decreased unless additional non-Federal funds were provided. The President has proposed the deletion pending congressional consideration of the health block grant proposal.

Senator MAGNUSON. Last year you made a similar proposal to reduce health grants, and it was rejected because the States were simply in no position to pick up these costs.

What has changed in the last year that would make you think we should allow this request?

Dr. MARSHALL. The change is the President's block grant proposal which would support, among others, those activities which previously were supported under the comprehensive public health grants to States program.

HYPERTENSION

Senator MAGNUSON. What can we actually do with the $3.75 million provided for hypertension in fiscal 1976?

Dr. MARSHALL. The funds appropriated in fiscal 1976 will be alloted to the States for establishing and maintaining programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension.

Senator MAGNUSON. What would it take to do the job right?

Dr. MARSHALL. The funds authorized in the statute will be adequate for establishing and maintaining existing hypertension programs, especially since other funds appropriated under section 314(d) or the President's proposed block grant program could be used to support these programs.

COMMUNITY HEALTH CENTERS

Senator MAGNUSON. When we compared 1975 levels of funding with your 1977 proposal, we discover that you are proposing for 1977 a 20-percent reduction in Federal support for the community health center program. Have the health care needs of the population served by these centers diminished?

Dr. MARSHALL. No. The budget proposed a 20-percent reduction for the project grants pending consideration of the "Financial Assistance for Health Care Act" which would consolidate 16 separate and categorical planning, construction and service delivery programs into a single block grant to the States.

COMMUNITY HEALTH CENTERS—GROWTH

Senator MAGNUSON. What kind of community health center growth can we expect with your budget?

Isn't there a need for more—shouldn't a strong chain of these centers be in place if and when we have national health insurance?

Dr. MARSHALL. This budget does not provide for any growth pending congressional consideration of the health block grant proposal. If this proposal is adopted, then each State will be in a unique position to determine if more services are required and to provide for them.

If national health insurance is enacted, the service capacity of these centers, and any additional capacity provided if the block grant is enacted, will be available for use.

The Department, of course, will continue its efforts to prepare community health centers for the advent of national health insurance. These efforts include, among others, the development of standards for providers of care, the mandating of improved procedures for project management, and the fostering of more cost effective arrangements of service delivery including integration of projects. Many of these activities are intended to help build and improve the Nation's capacity to deliver health services in medically underserved areas where such capacity is inadequate.

MATERNAL AND CHILD HEALTH

Senator MAGNUSON. What impact would your proposed reductions for maternal and child health care have on mothers and children who require prenatal and postnatal care?

Dr. MARSHALL. If the budget is approved as requested, and if the health block grant is not approved, there would be approximately 150,000 mothers who would not receive this care if States do not supplement the requested funds.

HEALTH MAINTENANCE ORGANIZATION

Senator MAGNUSON. The Health Maintenance Organization Act became law in 1973. Are you pleased with the progress we are making with this program? Has it become a success, and are we getting our money's worth?

Dr. MARSHALL. In spite of the economic downtrend that occurred during the initial implementation of the act and of the restrictive features of the act which are the subject of proposed amendments now being considered by the Congress, the program has made a good start. As of this date, over 160 organizations have received grants to undertake health maintenance organization development. Ten health maintenance organizations have been qualified and are now providing services to the public. An additional 20 applications for qualification are now under review. The health maintenance organizations are demonstrating the ability to control service utilization consistent with prior expectations of cost savings.

Based on 5-year program at a grant funding level of $15 million for fiscal year 1977 and fiscal year 1978, the development program will produce about 72 operational health maintenance organizations. It is anticipated that 41 of these will have become operational by the end of fiscal year 1977 and the additional 31 will be in operational status by 1979. These health maintenance organizations will provide an adequate base for evaluation of the effectiveness of this demonstration. Based on data which continue to be generated on health maintenance organization quality of care and cost savings, we believe that the Federal Government will receive a solid return on its investment in health maintenance organization development.

NUMBERS SERVED BY MIGRANT HEALTH PROJECTS

Senator MAGNUSON. How many persons will be served by migrant health projects in fiscal 1977 as compared to fiscal 1976? What proportion of the migrant population does this number represent?

Dr. MARSHALL. Based on the President's budget of $19,200,000 in 1977 approximately 353,000 persons will be served. This number might change if the health block grant were enacted. This represents 12 percent of the 3 million eligible migrant and seasonal farmworker population. In 1976, approximately 399,000 persons will be served if the funding level is $25 million.

THIRD-PARTY PAYMENTS

Senator MAGNUSON. Last year you stated that third-party payments could pick up the proposed budget cuts for migrant programs. How successful was this?

Dr. MARSHALL. In 1975, third-party reimbursements accounted for $1,400,000 (or 4 percent) of the total operating costs. In 1976, assuming the migrant program will be operating on a $25 million funding level, it is estimated the third-party payments will be $2,300,000 or 6 percent of the total operating costs.

SUCCESS OF FAMILY PLANNING

Senator MAGNUSON. What success have we had with the family planning program—give us some specific examples?

Dr. MARSHALL. Approximately 3.8 million low income women, 76 percent of whom are at or below 150 percent of poverty, are currently receiving comprehensive family planning services through organized programs. In addition to receiving the means with which to control their fertility, they receive preventive health care in the form of breast exams, Pap smears, VD testing, and other health screening tests for high blood pressure, anemia, and diabetes.

Access to services has been established in 2,920 of the 3,074 U.S. counties, in which 95 percent of our target population resides.

Twenty-nine percent of the patients served in fiscal 1975 were under 19 years of age which is a high-risk population.

The sharp and rapid marital fertility decline which occurred in the United States in the 1960's is considered entirely attibutable to a reduction in unplanned births. This was accomplished by more consistent use of contraception, greater use of the more effective contraceptive methods, and improved efficiency in their use. In fiscal 1975, 89 percent of clients were reported to have chosen the most effective methods, that is, pill, IUD, or sterilization.

COST EFFECTIVENESS OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Senator MAGNUSON. Is there any way to show a cost-effective relationship between what we spend on PSRO's and what we are getting in return?

Dr. MARSHALL. The PSRO program is intended to assure the quality and appropriate utilization of health care services. Peer review is the most effective means of assuring the public of accountability for the health services provided under third-party financing programs. One of the effects of peer review is to achieve reductions in the hospital length of stay. Although the PSRO's have not had a significant amount of experience in performing review, they have consistently demonstrated an ability to reduce length of stay in hospitals. For example, the Montana PSRO has been awarded a total of $625,857 to date, and the most recent information submitted shows that the average length of stay in this PSRO area has declined from 4.95 to 4.27 days. Federal beneficiaries for this time period were 9,800 and at the Montana average cost per hospital day of $137, a net savings of $918,100 was realized.

The Mississippi PSRO has been awarded a total of $1.2 million. Recent data from this PSRO shows that 6 months after review began in Mississippi, average hospital length of stay for medicare patients declined from 9.7 to 9.1 days. For medicaid the decline was from 5.86 to 5.51 days. Savings realized on medicare beneficiaries' length of stay were reported as $2.4 million.

The Sacramento PSRO has been awarded a total of $1 million. This PSRO reports that for medical admissions, length of stay declined from 6.80 days in 1974 to 6.38 in 1975 under review. For medicare

admissions, length of stay declined from 8.52 to 8.03 under review. At a per day rate of $150, the estimated savings on Federal patient care for 1975 was $3.1 million.

BUDGET INCREASE

Senator MAGNUSON. One of the biggest budget increases, is for the PSRO program. Do you feel that the results of this program warrant such an increase?

Dr. MARSHALL. The Department's budget for 1977 allows for full implementation of the PSRO program in order to have one quality assurance system for medicare and medicaid beneficiaries rather than the overlapping duplicate systems which exist now. The 1977 budget allows support for 120 conditional PSRO's and the funding of 83 new planning PSRO's, thus covering all 203 PSRO areas. We believe this strategy should allow the country to have a more efficient utilization of services, cost controls, and improvements in quality.

We feel that the results of this program definitely warrant a budget of $62 million in 1977. PSRO's are the most effective means of implementing a review system for Federal beneficiaries and for setting in place a quality assurance system for national health Insurance. As I explained earlier, PSRO's have already shown the ability to save Federal dollars.

IMPACT OF PROFESSIONAL STANDARDS REVIEW ORGANIZATIONS

Senator MAGNUSON. Can you cite any specific examples where the PSRO program has been successful in bringing down health costs?

Dr. MARSHALL. Although PSRO's have been performing review for a relatively short period of time, we have received some preliminary data from both the old and new conditional PSRO's. With your permission, I'd like to inert this data into the record. The information follows:

OLD CONDITIONALS

Several of the 14 old conditional PSRO's were conducting PSRO type review prior to undertaking PSRO review; thus, data from as far back as 1973 was available on review which is very similar to PSRO review. Thus their experience allows more opportunity to examine impact. We have gathered data from six PSRO's. Multnomah, Colorado, Prince Georges, Montana, Mississippi, and Minnesota on average length of stay for federally reimbursed patients for at least 1974 and 1975.

The 1974 data on length of stay which preceded PSRO review was compared to 1975 data which followed the introduction of PSRO review. For the six conditional PSRO's reporting complete data, the average decrease in length of stay was approximately 6 percent, or a half day's hospitalization. A rough estimate of the hospital utilization cost savings for 1975 due to reduction in length of stay across the six PSRO areas can be estimated. Based on a total number of Federal admissions of 450,000 in 1975 for the 6 PSRO areas and an average cost of $100 for each day of hospitalization with an average reduction per admission of half a day of hospitalization, the estimated savings in hospital utilization costs for 1975 was $22.5 million.

NEW CONDITIONALS

Of the 51 new conditionals given conditional status since June 30, 1975, relevant data was collected from several PSRO's with primary emphasis on changes in length of stay and effects of medical care evaluation studies on institutional care and medical education. It must be realized that very little data is available at present due to the short time that these organizations have been conditional and performing binding review. Only about 10 of these have been performing binding review for at least 4 months. The data collected represents changes for 3 months of review.

Length of stay data was available from four PSRO's: South Carolina, Idaho, Hartford County, and Greater Oregon. The data showed an average decrease of length of stay of 22.75 percent. For medicaid patients, length of stay declined from 7.94 days to 5.68 days. At an average cost of about $100 a day the resultant rough estimate of the saving in basic hospitalization costs was approximately $223 per episode of hospitalization. For medicare patients, length of stay declined from 11.21 to 9.3 days. At a cost of $100 per day, the resultant saving in basic hospitalization costs can be estimated to be approximately $189 per episode of hospitalization.

It should be emphasized that the more startling rate of change for length of stay among new conditionals, 22 percent as compared to 6 percent for old conditionals, is a function of their stage of development. The larger changes in length of stay may be expected when review is first implemented.

MEDICAL CARE EVALUATION STUDIES

In addition to information on the impact of PSRO hospital review, we have received some information on medical care evaluation studies which have been conducted by the PSRO's.

In the San Joaquin area PSRO, a transfer of medicare patients with tuberculosis to long-term care facilities resulted from concurrent review and criteria development. It was the community practice, while such a patient was in an acute facility, to require three negative cultures before transfer to a long-term care facility. However, each culture required 6 weeks with 2 week intervals. Thus, patients would be in an acute facility for about 22 weeks before transfer to a long-term care facility. The long-term care facilities insisted on this because of fear of losing their licensure and fear of infecting other long-term patients.

The PSRO brought together representatives of the long-term care facilities, the county public health department, the acute hospital discharge planners, and most important, local pulmonary disease specialists. It was generally agreed that no culture was necessary and only two smears were needed, one at the beginning of treatment, and one showing decrease in bacteria count after treatment. Therefore, stays for tuberculosis in acute hospitals have been reduced from 22 weeks to 2 weeks. Further, while some patients go to a long-term care facility after 2 weeks, many can be sent directly home on medication.

In the western Massachusetts PSRO a medical care evaluation study was performed to study the apparent excessive use of antibiotics in

patients undergoing vein ligations and stripping for varicose veins. At one hospital, antibiotics were used for this category of patients in 35 percent of the cases, during a 1-year period with a high of 60 percent during the last quarter of 1974. The professional activity study (PAS) norm for this parameter for hospitals in that area was 11 to 27 percent for the same period of time.

The study group included all 96 patients with vein ligations and stripping who had been discharged during 1974. The criteria and standards used were established by the surgical service on June 7, 1975, and stated that no patient in this category should receive antibiotics, with four specific exceptions.

Analysis of the cases showed that the use of antibiotics was indicated in 22 percent of the cases as compared with their actual usage in 35 percent of the cases. However, further analysis showed that antibiotic usage in two additional cases was justified under exception and that 9 other cases would have qualified under exceptions were it not for the fact that antibiotics had not been started preoperatively. Had antibiotics not been used in these 11 cases, the hospital's usage of antibiotics would have fallen below the PAS normative range. This proved that the criteria and standards adopted by the surgical service for this parameter were realistic, but that the problem existed in failure to put knowledge into practice.

It was recommended that henceforth, all cases of vein ligations and stripping be monitored during their hospital stay for the appropriateness of antibiotic usage, and that a similar study be repeated for 1975 discharges when data is available.

NATIONAL HEALTH SERVICE CORPS

Senator MAGNUSON. How successful has the Health Service Corps been in terms of getting health care to medically underserved areas?

Dr. MARSHALL. Currently, there are 1,400 areas designated as critical health manpower shortage areas. Of these, about 550 have been approved as eligible for National Health Service Corps assistance. The NHSC is staffing 270 of these sites providing service to about 600,000 people. The requested increase to 701 positions will permit service to an additional 252,000 people in 60 communities.

In addition to people served directly by our assignees, about 300,000 people are receiving services in 94 communities, which through NHSC assistance, have developed independent medical care delivery systems.

Senator MAGNUSON. The National Health Service Corps is one place where an increase was required. The committee considers this program as a very high priority. How many people is this program now serving?

Dr. MARSHALL. The program is currently serving about 600,000 people in 270 communities. The requested 701 position level will allow an increase in service to 252,000 people for a total of 852,000 in 340 communities.

Senator MAGNUSON. How many total positions are required to meet all the needs of medically underserved areas in the country? How are these required positions distributed by discipline? In other words, how many physicians, dentists, nurses, et cetera?

Dr. MARSHALL. We can determine the extent of critical needs by examining the current and projected designation of critical health manpower shortage areas (CHMSA's). At present, there are about 1,400 areas designated as CHMSA's; of these, 950 are critical medical shortage areas and 700 are critical dental areas. Some areas are designated for both.

Staffing in general is designed to lower the physician to population ratio in these most critical areas from 1:4000 or greater to 1:2000 and the dentist ratio from 1:5000 to 1:2500. In order to provide adequate health services to rural people, given the current need, we would require about 2,850 doctors, 1,400 physician extenders, 1,000 dentists, and 500 dental hygienists and auxiliaries. In addition, 8,500 personnel would be required to provide support for the medical providers. These could be hired locally.

By 1978–80, due to retirement, death, or resettlement of physicians currently practicing in rural areas, it is estimated that an additional 1,000 areas will be newly designated as CHMSA's. To provide services for these critical areas, an additional 3,000 doctors, 1,500 physician extenders, 1,000 dentists, and 500 dental hygienists and auxiliaries will be required.

PUBLIC HEALTH SERVICE HOSPITALS

Senator MAGNUSON. Isn't your proposal to close the eight PHS hospitals in direct conflict with the requirements of Public Law 93–155, which mandates that these hospitals remain open until Congress specifically authorizes them to be closed?

Dr. MARSHALL. The Department will submit legislation to Congress to authorize transfer to community use or closure of the eight PHS general hospitals. Until such time as specific congressional approval is given, the Department will continue to operate these hospitals.

Senator MAGNUSON. I understand you will propose that the patient care at the hospitals be handled through a contract—Is this correct?

Dr. MARSHALL. This is correct. Inpatient care of PHS beneficiaries will be provided through contractual arrangements with community hospitals and, where possible, with other Federal hospitals. Non-PHS beneficiaries would make similar arrangements.

Senator MAGNUSON. Isn't that a more expensive way to run the hospital?

Dr. MARSHALL. The cost to the Government to provide contract care will be greater than the cost of direct care provided in our present hospital system. However, that is not the basis for our proposal to close or transfer these hospitals. We believe there are better ways to furnish health care to our beneficiaries in a community setting.

Senator MAGNUSON. What data do your have to back up your answer?

Dr. MARSHALL. Although patient day costs in PHS hospitals have been consistently less than similar costs in nongovernmental hospitals, we have concluded that, after considering all of the factors, it would be in the best interest to close or transfer these facilities to the community. Occupancy rates in the PHS hospitals are low, 69 percent; primary beneficiaries comprise only 53 percent of the patients; commu-

nity hospitals are available to take care of PHS patients; and in five of the eight cities, there is an excess of hospital beds for community needs.

CLOSURE OR TRANSFER OF PUBLIC HEALTH SERVICE HOSPITALS

Senator MAGNUSON. The President's 1977 budget request includes the submission of a plan to the Congress for the closure or transfer of the Public Health Service hospitals. The Office of Management and Budget has attempted to close this hospital system for several years against the expressed wishes of the Congress. The most recent attempt in 1972–73 was overturned by the Congress. At that time, specific legislation was enacted which assured the continued operation of the hospital system, Public Law 93–155. In addition, this law requires that written, unqualified approval from the 314 A and B agencies accompany any recommendation from the administration which would alter the operation of the 8 general PHS hospitals.

In addition to total bed capacity, what special services, such as alcohol and drug detoxification and hemodialysis, are provided at the PHS hospitals?

Dr. MARSHALL. Special services provided at the PHS hospitals include alcohol detoxification and rehabilitation, drug detoxification and rehabilitation, hemodialysis, family planning services, geriatric day care, cardiac catheterization, retinal xenon photocoagulation, and special emergency and psychiatric services. These hospitals also provide extensive inpatient and outpatient medical and surgical services in support of health related and other ongoing community programs which care for persons who are disadvantaged or have special needs. I will be pleased to provide a listing of all these special services.

[The information follows:]

Inpatient Specialty Services Available

USPHS Hospitals

	Baltimore	Boston	Galveston	New Orleans	Norfolk	San Francisco	Seattle	Staten Island
1. General Surgery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
2. Orthopedic Surgery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. Thoracic Surgery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. Plastic Surgery	C.	Yes	Yes	Yes	Yes	Yes		Yes
5. Vascular Surgery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
6. Neurological Surgery	C.	Yes	Yes	Yes	Yes			Yes
7. Urology	Yes	Yes	Yes	Yes		Yes	Yes	Yes
8. Otolaryngology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
9. Ophthalmology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
10. General Medicine	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
11. Endocrinology	Yes			Yes		Yes	Yes	Yes
12. Cardiac Catheterization	Yes							Yes
13. Tuberculosis	Yes			Yes		Yes		Yes
14. Dermatology	C.	Yes	Yes	Yes	Yes	Yes	C.	Yes
15. Dialysis				Yes		Yes		Yes
16. Nuclear Medicine	Yes			Yes	Yes	Yes	Yes	Yes
17. Neurology	C.	Yes	Yes	Yes	Yes	Yes	Yes	Yes
18. Radioisotope Therapy	Yes	Yes	Yes	Yes		Yes	Yes	Yes
19. Deep X-ray Therapy	Yes							Yes
20. Radium Therapy	Yes							Yes
21. Neuropsychiatry - Closed Ward				Yes				Yes
- Open Ward	Yes	Yes		Yes		Yes		Yes
22. Rehabilitation	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
23. Dentistry - General	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Endodontics		Yes	C.	Yes	C.	Yes	Yes	Yes
Oral Surgery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Orthodontics	C.	C.	C.	C.	C.	C.		C.
Pedodontics	C.			Yes		C.		C.
Periodontics	Yes	Yes	C.	Yes	C.	Yes	Yes	Yes
Prosthodontics	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Note: "C." denotes services provided through consultants.

Blank spaces indicate services not provided.

Speciality Services Available
in the Outpatient Departments
USPHS Hospitals

	Baltimore	Boston	Galveston	New Orleans	Norfolk	San Francisco	Seattle	Staten Island
1. Cardiology	Yes	Yes		Yes		Yes	Yes	Yes
2. Cardiovascular Surgery					Yes			Yes
3. Dental	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. Dermatology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
5. Endocrinology-Metabolism	Yes			Yes		Yes	Yes	Yes
6. Gastroenterology	Yes			Yes			Yes	Yes
7. General Surgery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
8. Gynecology	Yes	Yes	Yes	Yes		Yes	Yes	Yes
9. Hematology				Yes		Yes	Yes	Yes
10. Internal Medicine	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
11. Leprosy		Yes		Yes		Yes		
12. Neurology	Yes			Yes	Yes	Yes	Yes	Yes
13. Neurosurgery					Yes	Yes		Yes
14. Obstetrics				Yes				
15. Opthalmology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
16. Orthopedic Surgery	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
17. Otolaryngology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
18. Pediatrics	Yes	Yes		Yes	Yes		Yes	Yes
19. Physical Medicine & Rehab.		Yes					Yes	
20. Plastic Surgery				Yes	Yes	Yes		Yes
21. Psychiatry	Yes	Yes		Yes	Yes	Yes	Yes	Yes
22. Pulmonary Diseases	Yes			Yes		Yes	Yes	Yes
23. Renal				Yes		Yes	Yes	Yes
24. Thoracic Surgery								Yes
25. Tumor		Yes		Yes		Yes	Yes	
26. Urology	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
27. Preventive Medicine	Yes					Yes	Yes	Yes

Note: Blank spaces indicate services are not provided.

HOSPITAL TRAINING PROGRAMS

Senator MAGNUSON. Are similar beds available in the community?

Dr. MARSHALL. Some of these services are unique in the total community but more often they are in limited supply or not otherwise available to disadvantaged segments of the population. However, State and local health planning agencies are the appropriate sources for this assessment with respect to specific communities.

Senator MAGNUSON. How involved are these hospitals in providing training to health professionals?

Dr. MARSHALL. During 1975, these hospitals provided training and education experiences to 3,522 employees, including 83 medical interns and 170 medical residents. There were 2,617 non-PHS employees who received similar training in these hospitals.

Senator MAGNUSON. Are the hospital training programs also serving their communities?

Dr. MARSHALL. Yes; the communities are served by the hospital training programs through the 2,617 non-PHS employees who received training in the hospitals.

Senator MAGNUSON. What training agreements are in effect with schools of medicine, dentistry, and nursing?

Dr. MARSHALL. The PHS hospitals and clinics currently have 274 academic affiliations and training agreements for all categories of health professionals, including affiliations with schools of medicine dentistry, and nursing.

Senator MAGNUSON. Do other hospitals rotate their residents through PHS hospitals as part of their training?

Dr. MARSHALL. Yes; many of the affiliation agreements with other hospitals provide for rotation of their residents through various clinical experiences in the PHS hospitals.

Senator MAGNUSON. What other training programs for pharmacists, physical therapists, social workers, dietitians, medical record administrators, and other health professionals use the PHS hospitals for practical experience and training?

Dr. MARSHALL. The hospitals provide direct training for these categories as well as clinical experience, on an affiliated basis, to students of the health professional schools in their communities.

Senator MAGNUSON. Are there other hospitals that are willing to assume such a role?

What impact will the hospital closure have on these training institutions?

Dr. MARSHALL. We are not able to answer that question at this time. We will provide the information for the committee's files.

PROVIDING OF COMMUNITY PROGRAMS

Senator MAGNUSON. Several of these hospitals have significantly expanded their responsiveness to the health needs of the communities under the Partnership for Health amendments of the PHS Act, section 328. What community programs are being provided at these hospitals?

Dr. MARSHALL. The programs being provided communities are quite numerous. I will be happy to provide this information for the record.

[The information follows:]

FORMALLY ESTABLISHED COMMUNITY PROGRAMS AND AGREEMENTS
AT THE U.S. PUBLIC HEALTH SERVICE HOSPITALS
BALTIMORE, MARYLAND

JOHNS HOPKINS UNIVERSITY MEDICAL SOCCER YOUTH SPORTS PROGRAM (EFFECTIVE 7/22/70)

When indicated by medical screening procedures, the PHS Hospital provides medical follow-up of participants in the above program. This program was developed in cooperation with the National Collegiate Athletic Association, the President's Physical Fitness Council and the Greater Homewood Resident's Association.

MAN ALIVE RESEARCH, INC. (EFFECTIVE 6/11/71)

This program provides methadone and antabuse therapy for drug and alcohol abuse. PHS Hospital provides outpatient medical, psychiatric and dental back-up services for the program.

PEOPLES FREE MEDICAL CLINIC, INC. (EFFECTIVE 4/9/74)

PHS Hospital provides general medical inpatient and outpatient services for clients of the above corporation which was established to create an alternative to inadequate health care facilities for the Waverly-Charles Village area of Metropolitan Baltimore.

FAMILY AND CHILDREN SOCIETY, FOSTER GRANDPARENTS PROGRAM (EFFECTIVE 5/3/74)

Under this program PHS Hospital provides physical examinations for applicants to the foster grandparents program, a state program providing part-time employment and other services for senior citizens.

BLUE CROSS OF MARYLAND, INC. (EFFECTIVE 9/24/74)

The PHS Hospital is now an affiliated member hospital of the Blue Cross of Maryland, Inc. Negotiations are underway to offer an HMO option to selected community groups.

O'DONNEL HEIGHTS MEDICAL CENTER, INC., BALTIMORE, MARYLAND (EFFECTIVE 10/31/74)

PHS Hospital provides general medical and dental inpatient and outpatient services to persons registered with the medical center.

JOHNS HOPKINS UNIVERSITY, COUNSELING AND PSYCHIATRIC SERVICES (EFFECTIVE 12/11/74)

This program provides psychiatric services to Johns Hopkins University students and three participating colleges. PHS Hospital has agreed to provide inpatient medical and psychiatric services for the psychiatric program.

MARYLAND STATE DEPARTMENT OF EDUCATION, DIVISION OF VOCATIONAL REHABILITATION (EFFECTIVE 1/16/75)

This state program is responsible for evaluation and rehabilitation of disabled persons in an effort to enable them to become gainfully employed when possible. PHS Hospital has agreed to provide inpatient and outpatient hospital services, professional services and special diagnostic services to individuals in the state program.

NORTH BALTIMORE CENTER, INC, COMMUNITY MENTAL HEALTH SERVICE (EFFECTIVE 1/20/75)

PHS Hospital provides general inpatient and outpatient hospital services as the sole medical backup for this community mental health program.

BALTIMORE CITY HEALTH DEPARTMENT GERIATRIC EVALUATION SERVICES (EFFECTIVE 3/31/75)

This city-sponsored service evaluates elderly residents in an attempt to determine if the individual can continue to live and function adequately in the community. The PHS Hospital provides comprehensive medical outpatient and inpatient services for this community program.

WOODBOURNE CENTER, INC. (EFFECTIVE 4/11/75)

An agreement with this residential treatment center for emotionally disturbed adolescents to provide general medical outpatient and selected inpatient services for the patient population.

ADDICT REFERRAL AND COUNSELING CENTER, INC. (EFFECTIVE 9/19/75)

An agreement to provide medical examinations and backup laboratory and therapeutic services at PHS Hospital for addicts undergoing rehabilitation at the above center.

GERIATRIC DAY CARE CENTER (EFFECTIVE 1/76)

An agreement with the Family and Children's Society of Baltimore for the development and operation of a day treatment center for the elderly at USPHS Hospital. PHS will provide key managerial and professional staff. Sponsored cooperatively by the Maryland State Administration for Services to the Aged and Critical Ill, this program will provide day health care to Federal beneficiaries and local community residents who are elderly and medically disabled.

BOSTON, MASSACHUSETTS

FAMILY PLANNING CENTER (EFFECTIVE 9/20/67)

Under an agreement with the Department of Public Health, Commonwealth of Massachusetts, the PHS Hospital provides complete facilities including all professional and ancillary staff needed for the operation of a family planning clinic for residents of the nearby communities of Allston and Brighton.

BOSTON CITY HOSPITAL DRUG ABUSE PROGRAM (EFFECTIVE 10/1/71)

An agreement through which the PHS Hospital provides space for an ongoing drug addiction treatment program operated by the city of Boston.

GALVESTON, TEXAS

GALVESTON COUNTY COORDINATED COMMUNITY CENTERS (EFFECTIVE 7/1/71)

Under this program, the PHS Hospital provides medical and ancillary services along with facility space for the operation of a comprehensive, family-centered community health service by Galveston County. This service is one element in an intradepartmental county program attacking poverty, ill health, underemployment, and illiteracy, with the aim of assisting individuals and families to become active participants in community life within the County.

GALVESTON COUNTY COMMUNITY ACTION COUNCIL ALCOHOLISM PROGRAM (EFFECTIVE 2/17/74)

The PHS Hospital provides backup medical treatment, medical counseling, and corrective medical appliances to clients of the Galveston Community Alcoholism Program.

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GALVESTON COUNTY COMMISSIONERS COURT (EFFECTIVE 7/15/74)

Under this agreement, the County Medical Examiner's Office is permitted t. use PHS Hospital post-mortem holding and autopsy facilities along with space for associated laboratory and clerical activities.

NEW ORLEANS, LOUISIANA

LOUISIANA STATE BOARD OF HEALTH HANDICAPPED CHILDRENS' PROGRAM (EFFECTIVE 5/1/68)

The PHS Hospital has agreed to provide backup outpatient and inpatient medical and plastic and/or orthopedic surgical care to handicapped children referred by the State agency.

PROTESTANT HOME FOR BABIES (EFFECTIVE 7/1/74)

Upon referral from the Protestant Home for Babies, the PHS Hospital provides outpatient and inpatient services to residents of the Home, a local nonprofit agency.

HOME FOR INCURABLES (EFFECTIVE 3/24/75)

The PHS Hospital provides a needed source of inpatient medical care for residents of the Home for Incurables in New Orleans.

CRIPPLED CHILDRENS' HOSPITAL (EFFECTIVE 7/1/75)

The PHS Hospital provides comprehensive outpatient and inpatient medical care, surgical ophthalmic care and general emergency medical care to patients of the adjacent Crippled Childrens' Hospital.

LIGHTHOUSE FOR THE BLIND (EFFECTIVE 1/2/76)

The PHS Hospital providesmedical care to employees of the agency who are injured on the job and to those participants in the various programs of the agency who are in need of medical attention.

NORFOLK, VIRGINIA

VIRGINIA COUNCIL OF ALCOHOLISM AND DRUG DEPENDENCE OF THE TIDEWATER AREA (EFFECTIVE April 1970)

The PHS hospital provides medical inpatient care to clients of the Virginia Council on Alcoholism and Drug Dependence upon referral from the Director of the Tidewater area program.

COMMUNITY SHARING OF RETINAL PHOTOCOAGULATOR (EFFECTIVE 6/9/70)

The Department of Ophthalmology, PHS hospital, is equipped with the only Xenon Retinal photocoagulator in the Tidewater area. By this agreement, non-beneficiary patients of ophthalmologists practicing in the Tidewater area benefit from use of the photocoagulator for the treatment of retinal diseases.

EASTERN VIRGINIA MEDICAL SCHOOL AND NORFOLK MEDICAL CENTER AUTHORITY (EFFECTIVE 7/9/74)

Under this agreement, the local medical school and medical center has established its new electron microscopy laboratory, allied pathology laboratories, microbology laboratory and its pathology research and training facilities within space provided by the PHS Hospital.

SAN FRANCISCO, CALIFORNIA

SAN FRANCISCO COMMUNITY HEMODIALYSIS UNIT, NORTHERN CALIFORNIA ARTIFICIAL KIDNEY CENTER (EFFECTIVE 12/9/69)

The San Francisco Community Hemodialysis Unit is located in and subsidized by the U.S. Public Health Service Hospital. Under this agreement, the hemodialysis unit is affiliated with the Northern California Kidney Center which coordinates placement of community patients for dialysis at the PHS Hospitals.

RICHMOND COMMUNITY MENTAL HEALTH CLINIC (EFFECTIVE 5/18/70)

This is an agreement with the city and county of San Francisco whereby the PHS Hospital supplies inpatient and outpatient mental health services to residents of the Richmond area of San Francisco who require such services but are unable to obtain private mental health care.

NATIVE AMERICAN HEALTH CENTER (EFFECTIVE 12/1/73)

This is an agreement with the Native American Health Centers of the California Urban Indian Health Council, Inc. and the California Rural Indian Health Board, Inc. by which the PHS Hospital provides inpatient care, especially for the treatment of alcoholism, to Bay area urban American Indians. Alcoholism therapy for registrants of the Centers is of limited availability elsewhere in the Bay area. The agreement also provides for medical and surgical inpatient services, emergency outpatient care, and specialty clinic care to American Indians who are registrants of the Centers.

UNIVERSITY OF CALIFORNIA, LANGLEY-PORTER INSTITUTE (EFFECTIVE 2/17/75)

The PHS Hospital provides space, inpatient support services, and medical consultation services for an Adolescent Psychotherapy Program maintained on the Hospital premises by the University of California. Psychiatric staff is provided by the Langley-Porter Institute of the University of California.

RICHMOND AREA MULTI-SERVICES, INC. (EFFECTIVE 11/15/75)

Under contract with the City and County of San Francisco, Richmond Area Multi-Services, Inc. provides outpatient psychiatric services for residents of the Richmond area of San Francisco who are unable to obtain private mental health care. The PHS Hospital has, in turn, agreed to provide psychiatric medication clinics and other outpatient services to clients of Richmond Area Multi-Services, Inc.

SEAFARERS MEDICAL CENTER (EFFECTIVE 1/1/76)

This medical center operates a non-profit clinic which provides a program of preventive medicine and diagnostic services for active and retired merchant seamen and their dependents, many of whom are economically disadvantaged. Under this agreement, the PHS Hospital provides emergency medical care, hospitalization and follow-up medical services to patients referred by the Seafarers Medical Center.

UNIVERSITY OF CALIFORNIA, SCHOOL OF DENTISTRY (EFFECTIVE 11/26/75)

An agreement with the Regents of the University of California, School of Dentistry, whereby the PHS Hospital provides space, facilities and staff for a program of dental research conducted jointly by the University of California and the PHS Hospital under a grant from the National Institutes of Health.

SEATTLE, WASHINGTON

SEATTLE FREE CLINICS (EFFECTIVE 4/9/71)

An agreement with the seventeen Free Clinics in Seattle to provide outpatient and emergency inpatient services.

STATE OF ALASKA, OFFICE OF VOCATIONAL REHABILITATION (EFFECTIVE 7/1/71)

The PHS Hospital agrees to furnish medical and dental care to patients referred by the State of Alaska - Tacoma Branch, Office of Vocational Rehabilitation.

SEATTLE INDIAN HEALTH BOARD (EFFECTIVE 7/1/72)

An agreement to provide a complete range of health and medical backup services to clients of Seattle Indian Health Board, including medical and dental services both inpatient and outpatient.

UNIVERSITY OF WASHINGTON DIABETES CENTER COLLABORATION (EFFECTIVE 5/28/75)

This is one of four diabetes research and service centers established throughout the U.S., under sponsorship of the National Institutes of Health, to improve competency in diagnosis and treatment of diabetes, and to provide professional training and patient education. PHS Hospital provides inpatient and outpatient services along with research space for the program.

STATEN ISLAND, NEW YORK

STATEN ISLAND HOSPITAL (EFFECTIVE 11/5/68)

Under this agreement, the PHS Hospital makes available its surgical research animal laboratory to the Department of Surgery of the Staten Island Hospital (non PHS) for the training of surgical residents and interns in surgical techniques. The PHS animal laboratory is the only one on Staten Island at which experimental surgery is performed.

NEW YORK CITY HUMAN RESOURCES ADMINISTRATION (EFFECTIVE 5/7/70)

This is an agreement to provide medical examinations and specific laboratory tests to trainees of the Human Resources Administration of the City of New York.

SILVER LAKE LODGE FAMILY DAY CARE CENTER (EFFECTIVE 7/27/70)

The PHS Hospital provides medical examinations and laboratory screening tests as required by the Bureau of Child Welfare, State of New York, to those disadvantaged persons who are participants in programs of the Family Day Care Center.

STATEN ISLAND MENTAL HEALTH HEAD START PROGRAM (EFFECTIVE 8/31/70)

Under this agreement the PHS Hospital provides medical examinations, laboratory tests, followup medical care and health evaluation services for family members participating in the Mental Health Head Start Program.

STATEN ISLAND COMMUNITY CORPORATION, FAMILY PLANNING AND HEALTH CLINIC (EFFECTIVE 8/28/72)

The PHS provides acute medical and surgical inpatient care and specialized outpatient care to patients referred by physicians of the Family Planning and Health Clinic of the Staten Island Community Corporation, the Federally designated poverty agency for Staten Island.

UNITED CEREBRAL PALSY CENTER (EFFECTIVE 9/25/72)

This is an agreement to provide medical, orthopedic and physical medicine services to patients selected by the United Cerebral Palsy Center on the basis of need and lack of other resources for evaluation.

MARINERS HARBOR COMMUNITY HEALTH CLINIC (EFFECTIVE 7/30/73)

The PHS Hospital agrees to provide medical and laboratory backup services to clients of the Mariners Harbor Community Health Center, established by the community and staffed by a physician from the National Health Service Corporation.

WILLOWBROOK STATE SCHOOL (EFFECTIVE 9/1/73)

Under this agreement, PHS Hospital provides acute inpatient and outpatient medical and surgical care to mentally retarded residents admitted to the Willowbrook Developmental Center pursuant to provisions of the Mental Hygiene Law of the State of New York.

NEW MORNING DAY CARE CENTER (EFFECTIVE 5/23/75)

This agreement provides emergency inpatient and outpatient medical and surgical care to children enrolled in this neighborhood day care program.

RICHBORO COMMUNITY MENTAL HEALTH CENTER, INC. (EFFECTIVE 6/25/75)

Under this agreement, the PHS Hospital provides inpatient medical care for those individuals with drug abuse related problems who are clients of the Richboro Community Mental Health Clinic.

CONTINUATION OF COMMUNITY PROGRAMS BY OTHER FACILITIES

Senator MAGNUSON. Will these programs be continued in the community by some other facility?

Dr. MARSHALL. There are no plans to continue these programs under Federal support. Whether these programs are to be continued in the community under other sponsorship is a matter for local decision.

Senator MAGNUSON. Are the hospitals fulfilling a health need that is not available elsewhere in the community?

Dr. MARSHALL. These agreements within the communities of the hospitals are developed in response to community needs and reflect a partial fulfillment of such needs. The State and local health planning agencies, are, of course, the appropriate source for assessment of the role of PHS hospitals in fulfilling health needs that are not available elsewhere in the community.

Senator MAGNUSON. There is no Federal support identified for the renovation of these facilities prior to turnover to community use. These hospitals are accredited by JCAH; however, requirements for new ownership in meeting physical requirements may require extensive renovation by the organization assuming control of the facility. Would you please comment on this?

Dr. MARSHALL. The Public Health Service hospitals are fully accredited by the Joint Commission on Accreditation of Hospitals. However, any change in ownership of a health facility ordinarily requires a reevaluation of the physical structure prior to certification and licensure. This reevaluation may require major renovation in order to comply with established standards and codes for newly licensed facilities.

The extent of renovation required for transfer of ownership is dependent upon the intended use of the facility, such as use as a nursing home, day care center, or hospital. Depending on this use, other funding sources are conceivably available to assist eligible groups to bring the facilities up to acceptable physical standards. There were no funds in the President's budget request specifically identified for the renovation of these hospitals prior to closure or transfer.

CUTBACKS IN EMERGENCY MEDICAL SERVICES

Senator MAGNUSON. If Congress accepted your low budget request for emergency programs, how would existing programs continue?

Dr. MARSHALL. We would be able to continue the funding of all operational systems. That is, we could provide first-year funding under section 1204 to all second-year 1203 grantees, and second-year funding under section 1204 to all first-year 1204 grantees. In addition, we would be able to provide first-year operational funding, section 1203, for four systems that had previously gone through the planning stage under section 1202.

Senator MAGNUSON. Would any be dropped?

Dr. MARSHALL. No existing operational systems would be dropped. However, because of the difference in levels of funding between the Appropriation Act of fiscal year 1976 and the President's budget for

fiscal year 1977, 30 systems from the planning stage would be unable to go operational—that is, progress from section 1202 to first-year section 1203.

THIRD-PARTY FUNDING

Senator MAGNUSON. In last year's budget, you made the assumption that there would be increased third-party funding for the maternal and child health program. What has happened wtih this? Did this third-party funding materialize?

Dr. MARSHALL. It did to some extent. The third-party reimbursement levels are estimated to be 5 to 8 percent of the operating costs of the program. This is a relatively small increase as compared with the 1975 estimated level of between 4 and 5 percent.

HEALTH MAINTENANCE ORGANIZATIONS

Senator MAGNUSON. Would it be a correct statement if I said HMO's serve a limited number of people and would not serve as a useful link in a national health network if and when national health insurance were enacted?

Dr. MARSHALL. I do not believe that would be a correct statement. First of all, all national health insurance proposals advanced to date are compatible with, and have provisions to include, HMO's as part of the health delivery program. HMO's would be a useful link in a national health network under national health insurance.

As to HMO's serving a limited number of people, I think we need only look at the growth in enrollment in HMO's since 1971 when the Federal Government first got involved in this effort. From 1970 to 1975, the number of prepaid health care organizations increased from 33 to 178 and enrollment increased from 3.6 million to almost 6 million. It is clear from this growth and the still greater growth potential that exists that HMO's serve more than a limited number of people.

BUREAU OF COMMUNITY HEALTH SERVICE RESCISSIONS

Senator MAGNUSON. I have inserted the justification for your proposed $127,804,000 rescission of important Health Services programs.

This proposal would cut very deeply into many of our very-high-priority programs, such as Health Centers, Migrant Health, and the National Health Service Corps.

The main rationale you have presented for these cuts is that the State and local governments ought to be carrying out these services. We have asked this same question time and time again, but will continue to ask: What leads you to believe that the States can pick up all of these programs with no cuts in services?

Dr. MARSHALL. It is the President's position that State and local governments should reorient their priorities, if necessary, to continue these programs. Based on the evidence to date, this is not likely to happen.

Senator MAGNUSON. Please give the committee some specific evidence of how each State would pick these cuts up.

Dr. MARSHALL. We do not have any specific evidence of how each State would pick up the cuts. Each State has the responsibility of assessing its own health priorities within the available resources. We believe that in making these assessments, many States will recognize the value of these programs and contribute funds for their continuation.

Senator MAGNUSON. How many people would, or could, be adversely affected by this rescission proposal?

Dr. MARSHALL. We do not believe any people would be adversely affected if priorities are reassessed by the State and local governments. If they do not assume their share of costs, however, we would estimate that approximately 1.2-million people would not receive services.

Senator MAGNUSON. What have you done to prepare the States to take over these programs? Be specific.

Dr. MARSHALL. In the rescission, we are not proposing State assumption of operating responsibility, only assumption of a larger portion of the cost. Nevertheless, our efforts to improve project efficiency, productivity, and financial management capacities will enhance their ability to operate, whatever the source of financial support.

END-STAGE RENAL DISEASE PROGRAM FUNDING

Senator MAGNUSON. Is there funding in the budget for the End-Stage Renal Disease program. If so, how will this be used?

Dr. MARSHALL. The fiscal year 1977 budget request for Quality Assurance includes $400,000 for staff support for the End-Stage Renal Disease program.

BURN CENTERS

Senator MAGNUSON. Last year we directed you to establish a plan and a program for a network of burn centers and to coordinate these efforts with the National Institute of General Medical Sciences. We expected a report to this committee concerning these efforts. I don't believe we have a report as yet. What is the status of these activities?

Dr. MARSHALL. A burn task force has been established and held its first meeting to outline its work schedule directed toward the joint report to be submitted to the congressional committee on burn centers. As directed by the Congress, the report will be submitted by April 27, within 90 days after enactment of the Labor-HEW Appropriation Act.

OFFICE OF THE ADMINISTRATOR

Senator MAGNUSON. What have you done in the last year to cut down the size of the Office of the Director for HSA?

Dr. MARSHALL. During fiscal year 1976, we have been reviewing each vacancy that occurs in the Office of the Administrator to ascertain if the position is essential to the operations of the Health Services Administration. As a result of this effort, a reduction of 5 man-years in fiscal year 1976 has been realized. In fiscal year 1975, the Office of the Administrator lapsed no full-time permanent position man-years. The other-than-permanent employment is being constantly monitored

and vacancies are not being refilled. Of the 10 other-than-permanent positions funded by the Office of the Administrator in fiscal year 1975 it is anticipated that there will be a reduction of two employees by the end of fiscal year 1976.

Senator MAGNUSON. Are you just transferring positions around or are you making real cuts?

Dr. MARSHALL. In the area of other-than-permanent position employment, we are making real cuts—two below the fiscal year 1975 level. In the area of full-time permanent positions, we are transferring positions within the Office of the Administrator to make more efficient use of the work force.

Senator MAGNUSON. Do you plan to use the funds which were requested for 1977: Are they all really necessary?

Dr. MARSHALL. The funds requested for fiscal year 1977 will be used to support program planning, evaluation, and legislation; communications and public affairs; financial, personnel, contracts and grants, and property management; and equal employment opportunity. In addition to providing funds for salaries and related benefits for the 177 positions, support moneys will be used for necessary travel, postage, printing, training, supplies, and replacement of five outmoded machines. Travel expenses will be held to $85,000 in fiscal year 1976 and 1977, a reduction of $9,000 below the $94,000 included in the original fiscal year 1976 congressional request. These funds are very necessary for proper management of this agency whose programs are in excess of $1 billion.

CONSULTANTS, EVALUATION COSTS

Senator MAGNUSON. How many consultants and evaluation programs do you have? Are they really worth the cost?

Dr. MARSHALL. The evaluation function for Health Services Administraiton is centralized in the Office of Planning, Evaluation, and Legislation.

The Office of Planning, Evaluation, and Legislation has no regular staff consultants. Rather, the Health Services Administration has negotiated basic ordering agreements with 13 consulting firms. These firms were selected competitively to perform designated tasks on an as needed basis. When consulting assistance is required for the implementation of an evaluation study, firms holding basic ordering agreements compete among themselves for the performance of such tasks. Because the time between task design and task implementation can be greatly reduced using the basic ordering agreement, this mechanism was deemed most appropriate for this type of short-term assistance.

Evaluation produces results useful over the long term as well as the short term. Many of the evaluation studies carried out by the Health Services Administration have impacted on policymaking and planning. For example, An Assessment of Emergency Medical Systems Adequacy not only provided information for a required report to Congress, but also has guided technical assistance activities of the agency.

Other studies have yielded results similarly useful for short-term program management decisions.

LEGISLATION FOR A LOAN AND LOAN GUARANTEE PROGRAM

Senator MAGNUSON. The forward plan for health stated you would propose legislation for a loan and loan-guarantee program to improve sanitation and housing conditions in migrant camps. What has been done with this proposal?

Dr. MARSHALL. As of this time, the proposal for legislation for a loan-guarantee program has not been submitted. The proposal was submitted to the National Migrant Health Advisory Committee for consideration and rejected as not a substantive initiative for the improvement of the broad problem of the conditions of migrant labor housing.

EMERGENCY MEDICAL SERVICES

Senator MAGNUSON. Emergency medical services is a program which the committee thinks very highly of. Specifically, why are you proposing to cut this program back so much?

Dr. MARSHALL. We feel that this program is successfully demonstrating emergency medical service technique to local communities and has resulted in substantial numbers of lives saved. We further believe that the President's budget contains adequate funds to carry out this demonstration effort and that further implementation should be State and local responsibility.

CONSUMER REPRESENTATION IN PSRO'S

Senator MAGNUSON. What are you doing to see to it that the PSRO boards are representative of all groups and lay citizens involved in health care, such as nurses and allied health professionals?

Dr. MARSHALL. The responsibility for involving consumers is assumed voluntarily by PSRO's and the statute does not allow DHEW to mandate consumer involvement. Only physicians are permitted to be members of a PSRO and only physicians may make final review determinations regarding the practices of other physicians. The sole statutory provision which allows DHEW to require provision of an opportunity for consumer participation relates to statewide professional review councils.

These councils will exist in States with three or more conditional or operational PSRO's and currently 18 States fulfill this criterion.

However, the Department has endeavored to provide for meaningful consumer participation in the development and administration of local PSRO's by encouraging consumer representation on the governing body of the PSRO; even though they may not be PSRO members.

Of the 65 existing conditional PSRO's 14 or 22 percent have voluntarily elected consumers to their governing boards.

For example, 4 of the 15 members of the Board of Directors of the Wyoming PSRO are consumers. The Colorado PSRO has established a consumer advisory council which includes welfare recipients and representatives from senior citizen and labor organizations.

It should also be mentioned that 16 PSRO's have voluntarily elected allied health professional to their governing boards.

PSRO MEMBERSHIP

Senator MAGNUSON. What percentage of physicians in PSRO areas are PSRO members?

Dr. MARSHALL. Nationwide, approximately 1 physician in 3, or 106,000 out of 340,000, is a member of a PSRO project. About 45 percent of the physicians in areas where PSRO's have been established are PSRO members. In the 14 areas which have had conditional PSRO's for 2 years, physician membership is about 58 percent.

There is no doubt that physician involvement in the PSRO program is increasing considerably.

PUBLIC HEALTH SERVICES HOSPITALS

Senator MAGNUSON. Are you still in compliance with the law which mandates that the PHS hospitals remain in full-scale operation?

Dr. MARSHALL. The PHS hospitals are in full-scale operation. With the appropriation just recently enacted by the Congress, we shall be able to reach full strength in providing services, as mandated by the law. We will be doing all that we possibly can to maintain the levels of care the same as or better than they were in fiscal year 1973.

Senator MAGNUSON. Where will the patients go who are presently being treated at the PHS hospitals?

Dr. MARSHALL. We propose to continue direct outpatient care of the PHS primary beneficiaries through PHS operated outpatient clinics. For inpatient care, the Public Health Service would contract with medical facilities in the home communities where these beneficiaries live, Patients, other than PHS primarily beneficiaries, would have their medical care provided by their sponsors in local community or other governmental medical care facilities.

Senator MAGNUSON. Will any services be reduced?

Dr. MARSHALL. No services should need to be reduced. By operating PHS outpatient clinics and contracting for inpatient care or other services as needed, our primary beneficiaries should be able to receive the same level of services. The same should be true for nonprimary beneficiaries, where other local medical care facilities would continue to provide the necessary care.

Senator MAGNUSON. What will happen to the PHS dependent beneficiary program under your proposal?

Dr. MARSHALL. Under our proposal, retirees and dependents currently receiving inpatient care in our facilities would continue to be entitled to care under the dependents' medical care program. Under that program, these beneficaries would receive health care services in community hospitals or in other Federal facilities.

Senator MAGNUSON. Will the Bureau of Medical Services' research and training programs continue to function under your proposal?

Dr. MARSHALL. The closure of the PHS hospitals will necessitate termination of practically all current training programs and research activities. Training commitments to health professionals would be fulfilled through salary payments while they complete their training in other institutions. Some research would continue to be done at the PHS Leprosarium at Carville, La.

EVALUATION STUDIES

Senator MAGNUSON. For the record, list your present evaluation projects and exactly how you expect them to be used to improve programs or save money.

Dr. MARSHALL. At present, the Health Services Administration has just completed its fiscal year 1975 evaluation agenda, and is beginning the implementation of its fiscal year 1976 evaluation plan. Therefore, at present we have only 12 evaluation projects in process. Many of these studies will be completed shortly, and many new fiscal year 1976 evaluation projects will soon be started. I have some detailed information on this matter which I will submit for the record with your concurrence. The information follows.

The product of one project, "Development of an Evaluation Workbook for Emergency Medical Services," will serve as a guide to evaluating the impact of the Emergency Medical Services Systems Act of 1973 in meeting the needs of communities which have received grant support.

A study on the "Characteristics of High Frequency Users in Community Health Centers" will determine if the needs of high frequency users of the centers can be met by less expensive methods.

A study, "Physician Productivity in Public Health Service Hospitals," concerning physician utilization at the Staten Island Hospital at a particular point in time has produced data and a methodology for use at other Public Health Service hospitals. Specific findings at Staten Island included identification and measurement of imbalances between patient workload and physician staffing for certain hospital specialties, quantification of the existing division of time between patient care and training for interns and residents, and identification of tasks currently performed by physicians which could be transferred to less skilled personnel. The results will assist not only in physician position allocation among hospitals and specialties, but also in a continuing Health Services Administration effort to improve individual physician productivity.

A study on the "Development of Accessibility Indexes for Ambulatory Care Providers" has produced a methodology for describing the accessibility of ambulatory care centers. The near term impact of this study will be that neighborhood health center data will be analyzed to determine the effect of transportation and outreach expenditures on utilization. This information will assist the neighborhood health center program in optimizing its transportation and outreach funds.

A "Comparative Cost and Financial Analysis of Ambulatory Care Providers" has provided two important pieces of information. The first data set indicates the relative cost of providing ambulatory care across Health Services Administration ambulatory care settings. Such information enables program managers to determine how their programs' costs compare to those of other programs. The second data set presents an analysis of the potential impact of National Health Insurance on Health Services Administration programs. This analysis suggests that high cost sharing would seriously reduce the utilization of Health Services Administration ambulatory centers. It appears that Health Services Administration centers do provide care that would not otherwise be available to large numbers of people.

A major effort currently underway is a "Collection of Data for Determining the Impact of National Health Insurance on Bureau of Community Health Services Clients and Projects." The purpose of this study is to gather data on Bureau of Community Health Services program users that will enable analysis of the potential impacts of National Health Insurance on Bureau of Community Health Services program operations. This knowledge will assist Bureau of Community Health Services in making recommendations to the framers of National Health Insurance and in turn will enable Bureau of Community Health Services to modify its program operations in order to optimize self-sufficiency under the various forms of National Health Insurance that might eventually be enacted. The data on Bureau of Community Health Services program clients will also be useful in determining the appropriateness of current program services to client needs.

Another study which will be completed soon is entitled "The Development of a Staging Methodology for Evaluating the Quality of Medical Care." This methodology for evaluating the quality of ambulatory medical care is both more extensive and less costly than the traditional medical audit and can be used in conjunction with a targeted medical audit as a highly effective and efficient evaluation tool. The standard medical audit has a limited capability for determining areas of program weakness because of its scatter shot approach in examining a small sample including both problem and problem-free courses of care. Staging has a broad capability of identifying problem areas in clinics because it encompasses virtually all records of hospitalized patients. Service weaknesses suggested by the staging study can be investigated in depth with targeting medical audits which will be more effective than traditional unfocused audits.

The "Development of a Financial Information System for the Determination of Ambulatory Care Costs by Disease Diagnosis" is another on-going evaluation effort of Health Services Administration. The purpose of this study is to develop, document and test a financial information system that will provide full and complete determination of ambulatory facility health care costs by specific disease diagnosis. The results of this effort are expected to have long range benefits in terms of improving Health Services Administration's monitoring capability. Specifically, the implementation of a system that relates disease diagnosis to cost will allow Health Services Administration to evaluate the efficiency and effectiveness of ambulatory care providers both in absolute and relative terms.

The purpose of the "Patient Data Analysis" study is to analyze data on family planning patients relative to: characteristics of patients, contraceptive data, types of categories of services provided per patient, cost per patient served, quality of services, and so forth, and to validate the data for reliability. This study involves the identification of existing significant evaluative data and verification of the accuracy of these data in order that the program may determine (1) the degree to which it is reaching its priority target populations, low income women and teenagers, and (2) the types of services being delivered and the cost and quality of providing these services. Ultimately the results of this study will be used by the program in making necessary modifications for more effectively and more efficiently meeting its mandate.

A "Study of the Physician Directed and Physician Extender Directed Clinical Setting" compares two modes of family service delivery in order that information relating to cost, efficiency, optimal structure and utilization may be obtained. The results of this study will be used by the program in determining the degree to which the utiilzation of physician extenders in the delivery of family planning services impacts upon service utilization, quality and cost.

A soon to be completed evaluation study, "Identification of Factors that Result in the Successful Recruitment and Retention of Necessary Professional Manpower," has found that the foliowing five factors were most often given by physicians as being important in their decisions to leave Government service: (*a*) inadequate compensation; (*b*) to obtain residency training: (*c*) poor living conditions; (*d*) poor professional conditions; and (*e*) lack of career guidance. The results of this study will be used as input to policy decisions regarding retention and recruitment of physicians.

The "Evaluation of Surveyor Training" involves the validation of an existing task inventory in a national sample. An occupational analysis will be produced from the validation process. From the occupational analysis, surveyor performance criteria and standards will be established. A skills and knowledge test for interim credentialing of surveyors will be developed from the performance criteria and standards. A handbook based on the skills and knowledge will be developed and distributed to the regional offices and the States. The results of this study will be used to improve the Public Health Service program that trains surveyors who inspect all providers for medicare and medicaid beneficiaries.

NEW FORMULA GRANT PROGRAM

Senator MAGNUSON. How many administrative layers would be required under the new formula grant program?

Dr. MARSHALL. In terms of the Federal responsibility for these activities, no new administrative layers would be required and fewer Federal positions would be needed.

REGULATIONS—HEALTH CENTERS

Senator MAGNUSON. When will the regulations be issued for the Health Centers—What is holding them up?

Dr. MARSHALL. The regulations are in draft and are currently being reviewed by general counsel. We are projecting final publication of effective regulations May 15–30. Time has been required in development of the regulations due to the complexity of the legislation and the issues to be resolved.

COMMUNITY HEALTH CENTERS—PROPOSED CUT

Senator MAGNUSON. You are proposing that we cut back the community health centers program by over 25 percent.

How many persons are presently being served by community health centers?

Dr. MARSHALL. Community health centers in fiscal year 1976 are providing services to approximately 1,872,000 persons in medically underserved urban and rural areas of this Nation.

Senator MAGNUSON. What fraction of our medically-underserved population does this represent?

Dr. MARSHALL. This represents 3.8 percent of the medically underserved population.

COMMUNITY HEALTH CENTERS—PREVENTION

Senator MAGNUSON. Have the neighborhood health centers been successful in providing preventive health care? If not, why not?

Dr. MARSHALL. Yes; community health centers are ambulatory health care programs, located in urban and rural medically underserved areas, which integrate a broad range of health and social services into a single organization. These projects assure accessible ambulatory care and incorporate sound preventive health measures.

The provision of comprehensive ambulatory health care services which emphasize prevention tends to lower total health care cost through the lessening of need for expensive inpatient care. A study completed October 31, 1973, on the hospital utilization experience of persons using five health centers shows a marked decrease in inpatient hospital utilization, as compared with the national experience. For the five centers participating in the study, the average hospitalization experience was 762 hospital days per 1,000 patients. The national average was 1,160 hospital days per 1,000 patients. The hospital usage in these five centers is at a rate significantly lower than experienced with primary care providers (1,109 days) on indemnity plans (864 days) and approaches group practice experience (526 days).

COMMUNITY HEALTH CENTERS

Senator MAGNUSON. Why are you proposing to reduce support for 20 centers and 77 rural health initiative projects that served 564,000 people in 1976? Where are these centers expected to find support for the services they provide? Is not a reduction of support contrary to a mandate by Congress, as expressed in the recently enacted Public Law 94–63, to expand this program?

Dr. MARSHALL. The 1977 budget request reflects a 20 percent reduction in categorical grant programs pending congressional consideration of the health block grant proposed. Centers will have to seek funding support from State and local authorities or from private sources. However, if the "Financial Assistance for Health Care Act" as proposed goes into effect, States will be permitted to set their own priorities.

You are correct in stating that this funding request will not enable us to carry out the mandate in Public Law 94–63.

REDUCTIONS OF NUMBERS OF PEOPLE SERVED

Senator MAGNUSON. The question that, of course, comes to mind immediately when we see the wholesale reductions of numbers of persons served under the maternal and child health program is: What is going to happen to those persons—mothers, babies, children—who will have to be left out? For instance, about a million fewer children will be immunized against polio, rubella, and diphtheria under the MCH program in the coming year. Have you considered the consequences of this?

Dr. MARSHALL. The questions you have raised are very legitimate. We are encouraging States to maintain their programs in these critical areas. The Department has selected prevention as a top priority for fiscal 1977. Hopefully, States would not elect to trade off prevention programs for others of a less critical nature.

Senator MAGNUSON. Can we expect a large jump in the incidence of these diseases or will these services be provided through some other source?

Dr. MARSHALL. If States give prevention top priority in their funding program, we would not expect to see large increases in the incidence of the diseases.

MATERNAL AND CHILD HEALTH POSITIONS

Senator MAGNUSON. In previous years' Senate and House reports, positions have been specifically provided for the MCH program—are all of these people now hired and operating the way we intended?

Dr. MARSHALL. Currently, 90 percent of these positions are filled, and we are currently recruiting for the balance.

Senator MAGNUSON. Please provide for the committee with a specific number of positions which are filled and an organizational chart.

Dr. MARSHALL. Mr. Chairman, there are 153 full-time permanent positions filled and an additional 13 other-than-full-time permanent on duty. At this time, I will submit for the record an organizational chart for the MCH program which is based on the functions of the Bureau of Community Health Services. This chart is based on full-time permanent manyears rather than positions due to the functional duties of the Offices and Divisions within the Bureau.

[The information follows:]

BUREAU OF COMMUNITY HEALTH SERVICES

MATERNAL AND CHILD HEALTH PROGRAM

Central Office	1976 Distribution of Manyears
a. Associate Bureau Director	11
b. Office of Program Support	14
c. Office of Program Development	9
d. Office of the Director	7
e. Division of Policy Development	5
f. Division of Clinical Services	33
g. Division of Health Services Financing	5
h. Division of Monitoring and Analysis	9
Subtotal, Central Office	93
i. Regional Offices	77
Total, MCH	170

a. The Associate Bureau Director's Office is the point of accountability for the MCH Program. It develops and establishes national objectives, tracks Regional Office activities, develops criteria for funding and resource allocation, measures program performance and assures that program needs are met.

b. As the administrative management arm, the Office of Program Support provides guidance and direction on financial management activities of the MCH Program (including budget preparation, personnel and resource allocation, etc.), interprets management policies and provides day to day administrative support.

c. The Office of Program Development develops and implements long range MCH plans, tracks legislative development and hearings related to mothers and children (including preparation of opening statements, testimony and issue papers), develops and monitors special studies on

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maternal and child health and develops and maintains resource data rela.ed to the program.

d. The Office of the Director provides the overall leadership and direction for MCH activities. This Office serves as a central point of reference for program continuity, establishing and communicating program policies and priorities, providing overall program support and stimulating the development and progress of MCH activities.

e. In the Division of Policy Development MCH regulations, guidelines, related standards necessary for the operation of the program as well as program performance measures are developed and adminfstered.

f. Professional and technical assistance, research related to mothers and children, staff training and the development and dissemination of materials on research findings and other MCH informational and educational matters are among the activities carried out by the Division of Clinical Services.

g. The Division of Health Services Financing is concerned with financial and business management aspects of MCH, particularly as they relate to determining the status of and maximizing third party reimbursement [illegible].

h. The Division of Monitoring and Analysis plans, directs and administers the development of information systems and project and program analysis and assessment tools for the MCH Program. Analyses are conducted to supplement the knowledge of existing patterns and trends in the health care of mothers and children.

i. Central Office staff coordinate their activities with the Regional Offices which carry out such functions as allocating resources, interpreting agency policy,monitoring grant awards and identifying policy issues.

MATERNAL AND CHILD HEALTH RESEARCH AND TRAINING

Senator MAGNUSON. What level of funding is required in fiscal 1977 to at least maintain MCH research and training support at the fiscal 1975 level?

Dr. MARSHALL. $23.9 million is required.

Senator MAGNUSON. What is required for research and training funding to continue support of the Pediatric Pulmonary Centers?

Dr. MARSHALL. The fiscal 1976 funding level of $2 million would need to be continued in fiscal 1977. This amount would not provide for any program expansion beyond that initiated in fiscal 1976.

COST OF CRIPPLED CHILDREN SERVICES

Senator MAGNUSON. How much would it cost to take care of all the crippled children in need of care?

Dr. MARSHALL. It is conservatively estimated that there are 9 million handicapped children in need of care. If States shared in the cost of care at the same level as at present, the Federal cost would be between $1.1 and $1.2 billion. The Federal participation in State programs ranges from 10 percent to 70 percent.

EVALUATION PROCEDURES ON MCH PROGRAM

Senator MAGNUSON. Last year a GAO report stated that the maternal and child health program evaluation procedures were not as good as they should be. What have you done to upgrade them?

Dr. MARSHALL. We are initiating new reporting requirements designed to monitor the program more closely. As a result of the GAO study, we are looking critically at the health status of population within States such as infant mortality, available resources, coordination of the MCH program with other Department programs, that is, neighborhood health centers; health in underserved rural areas, et cetera. Guidelines and guidance materials are now being developed to assist States in upgrading their programs.

SUDDEN INFANT DEATH SYNDROME PROGRAM

Senator MAGNUSON. What are you doing to get the SIDS program moving?

Dr. MARSHALL. A total of 24 projects have been funded. These projects provide counseling services to families affected by SIDS, and collect SIDS related research data provided by pathology reports from autopsies. Two films have been completed, one for SIDS parents as the primary audience, and the second to be used as a training tool for police and other emergency responders. Also, there has been distribution of SIDS informational materials to maternal and child health experts and others indicating a specific interest in SIDS. A national reporting system is being developed, a scientific exhibit on SIDS is being prepared for showing at annual professional meetings, a conference will be held for pathologists and protocol developed for autopsy procedures, and 5 biregional conferences will be held for State and local health agencies.

Senator MAGNUSON. What kind of progress are you making?

Dr. MARSHALL. Six to eight new projects are to be funded in areas not previously awarded, bringing the total number of projects funded in fiscal 1976 to 30 or 32. Counseling services are being provided to potentially 3,350 families; one film has had 1,117 showings, 14,800 viewers and 100 prints in circulation among groups such as the American Academy of Pediatrics, American College of Obstetrics and Gynecology, State and Territorial Nurses Association, hospital in-service programs, and schools of nursing; educational activities conducted by project staff attended by 1,257 health professionals and other community workers; and 175,000 copies of SIDS informational materials distributed to 5,000 maternal and child health experts and others indicating a specific interest in SIDS.

Senator MAGNUSON. Your budget contains zero for the sudden infant death program. Why do you think this program should come to a halt? Be specific.

Dr. MARSHALL. We do not believe this program should be discontinued. Rather, we believe that the States should reassess their priorities and realine activities in ways which will allow continuation of important programs such as SIDS. We believe the new block grant approach will help give States the flexibility required to accomplish such realinements.

Senator MAGNUSON. What accomplishments of the SIDS program can you cite?

Dr. MARSHALL. To date, Mr. Chairman, 1,257 health and emergency personnel have been instructed regarding SIDS; counseling services have been provided for 242 families in the first 3 months of program operation; the general information film, "After Our Baby Died," has been viewed by 14,800 persons and has been shown 1,117 times as of December 31, 1975; and two other films are now being produced.

OPERATING CAPACITY OF FAMILY PLANNING CENTERS

Senator MAGNUSON. Are family planning centers operating at capacity—if not, why not?

Dr. MARSHALL. Most family planning centers are operating at capacity within their budget level. The program was operating under a continuing resolution for the first half-year and it is assumed that in the third quarter there will be a rescission of $21,180,000. This 20 percent reduction in the 1976 appropriation level has resulted in staff cutbacks and reduced clinic hours.

MIGRANT HEALTH

Senator MAGNUSON. Why are you proposing to reduce Federal support for 8 projects and 46,000 people served in 1976? How do you reconcile this proposal with the congressional mandate to expand the migrant health program?

Dr. MARSHALL. We are proposing this reduction pending congressional consideration of the health block grant proposal. Hopefully States, under the block grant will continue to provide adequate funding for health care to migrants, and this reduction will not be made. I would agree that the budget proposal does not fulfill the mandate you cited.

HEALTH MAINTENANCE ORGANIZATIONS

Senator MAGNUSON. We have been advised by the General Accounting Office that the Department still has not completed all the regulations necessary to implement the Health Maintenance Organization Act of 1973. Have you evaluated the causes of this extraordinary delay in implementing the act and taken any steps to assure that such will not occur in the future? The contention that the Department could not develop these regulations because only one lawyer was available to work on them isn't an acceptable reason, only a contributing factor.

Dr. MARSHALL. We share your concern, Senator. There are many contributing factors that slowed the publication of regulations implementing the health maintenance organizations program. Today, all regulations implementing the health maintenance organizations program, except the regulations covering the continuing regulations, are published in final form. Specifications for the, as yet unissued, regulations are in the Office of General Counsel awaiting final drafting.

The statute itself, and the internal ambiguities that it presented was as large a contributing factor as the small staff of general counsel. There has been extraordinary interest in the act on the part of the health care industry, Members of Congress and congressional staff and among other components of the Department. Allowing for full discussion of the issues has been time consuming. Amendments to the statute are now being considered in the Senate. These amendments have already passed the House. It is expected that they will remove some of the ambiguity that caused delays.

Senator MAGNUSON. In the Spring of 1974 the Department of Health, Education, and Welfare stated that about 170 new operational health maintenance organizations would be developed with Federal assistance at the end of the 5-year program. At the end of less than 2 years you are now saying less than 80 will be operational. Please explain.

Dr. MARSHALL. The estimate of 170 new operational health maintenance organizations that would be developed was based on preliminary estimates of health maintenance organization development as expressed by interested groups. The anticipated number of high quality applications has not materialized in spite of our technical assistance and program efforts. The amounts requested and appropriated for the health maintenance organization program have been substantially lower than previously projected and as a direct result the lower number of new operational health maintenance organizations are expected. This number is still a large enough group to provide a meaningful demonstration of the health maintenance organization concept which was the intent of Congress when it passed the Health Maintenance Organization Act.

GENERAL ACCOUNTING OFFICE REPORT

Senator MAGNUSON. The General Accounting Office report to Congress last November on health maintenance organizations was very critical of the program to date. One criticism was that the enrollment for many health maintenance organizations was too low to enable the

organization to become viable. What is the average health maintenance organization enrollment at this time?

Dr. MARSHALL. The report surveyed primarily health maintenance organizations which only recently became operational. It is true that for the first few years enrollment will likely remain at a moderate level. However, as the organization matures it becomes financially viable. This becomes apparent when comparing the enrollment of health maintenance organizations who were operational before 1971 and those who have recently come into being. New health maintenance organizations enrollment has grown substantially during the last few years. Thirty-five organizations which have received Federal support prior to the passage of the Health Maintenance Organization Act are now operational and serve 350,000 enrollees. Under title XIII, the Health Maintenance Organization Act, 166 organizations have received direct grant support to develop qualified prepaid health plans. Developmental periods of projects supported under the act are anticipated to take from 1 to 3 years, thus most of these organizations are still in the developmental stage. To date, 10 health maintenance organizations have been qualified under the act and serve a total of 53,101 enrollees. Overall, the enrollment in prepaid health care organizations started since 1971, when the Federal Government became directly involved, is nearly 1 million.

Senator MAGNUSON. What percent of health maintenance organizations enrollees are currently covered by medicare, medicaid or have their premiums paid directly or indirectly by the Federal Government?

Dr. MARSHALL. The Federal Government has a substantial stake in health maintenance organizations. There are approximately 1.3 million enrollees in the Federal programs of medicaid, medicare, and the Federal employees health benefits plan. Total payments to the health maintenance organizations serving this enrollment is approximately $276 million per year. Cost savings to the Government at this level of financial participation amount to approximately $55 million annually in comparison to costs in non-health-maintenance organizations health plans. Approximately 23 percent of the Nation's total health maintenance organizations enrollees are covered by medicaid, medicare, or the Federal employees health benefits program.

Senator MAGNUSON. Has the percentage of nonpoor enrollees in health maintenance organizations increased significantly in the last 2 years?

Dr. MARSHALL. Yes. The greatest increase in health maintenance organizations enrollment during the last 2 years has increased among nonpoor persons. For example, the total has increased from 5 million to approximately 5.7 million, while the total enrollment in medicaid is only 300,000 and has increased only moderately during the past 2 years. The number of health maintenance organizations that have contracted with States for medicaid is now 15, and it has not substantially changed during the 2-year period. Of all medicaid eligibles, only 3.5 percent are enrolled in health maintenance organizations.

Senator MAGNUSON. Is the Department of Health, Education, and Welfare still funding health maintenance organizations which must compete in the same geographical area for enrollees?

Dr. MARSHALL. Yes. The Department disagreed with General Accounting Office on this recommendation and feels that many factors must be taken into consideration when more than one health maintenance organization is competing for funding in the same geographical area. These factors are: the size of the population, income level of the population, the types of health maintenance organizations—group practice or individual practice associations—and the level of funding requested. These are Albuquerque, Minneapolis, Los Angeles, Rochester, and Chicago among others. Of the 79 pre-Health Maintenance Organization Act projects funded by the Department, 35 are now operational serving approximately 350,000 enrollees. The annual cost savings experienced by this level of enrollment amounts to $\$10\frac{1}{2}$ million annually. Thus, the total Federal grant investment of $31.5 million will be recouped in only 3 years by these health maintenance organizations. As their membership increases with maturity, the cost savings will be even greater.

Senator MAGNUSON. General Accounting Office recommended that operational loans be contingent upon a health maintenance organization reaching a minimum enrollment within a specified period of time. Has this recommendation been implemented?

Dr. MARSHALL. The Department did not agree with this recommendation because an organization can be found to be qualified and receive a loan commitment prior to the organization becoming operational. To deny the organization the opportunity of such financial backing would be to place them in an untenable position. However, the decision to award a loan is contingent upon our evaluation of the marketing forecast proposed by the applicant, which is monitored closely to assure that enrollment goals are being met before action would be taken. We believe that this position is fully in accord with the intent of the Health Maintenance Organization Act.

The General Accounting Office report unfortunately caused unnecessarily poor publicity for the Health Maintenance Organizations program. The General Accounting Office itself has issued new releases indicating that the newspaper statements were inaccurate and misleading in the context in which they were presented. The major concern is that the report was not an assessment of the current Health Maintenance Organization program but covered the health maintenance organizations established prior to the passage of the Health Maintenance Organization Act in 1973. I want to make this point clear for the record.

JUSTIFICATION

Senator MAGNUSON. Thank you. We will put your justification material in the record at this point.

Dr. MARSHALL. Thank you, Mr. Chairman.

[The justification follows:]

Justification

HEALTH SERVICES

For carrying out, except as otherwise provided, titles III, V, X [1/], XI, XII, and XIII of the Public Health Service Act, the Act of August 8, 1946 (5 U.S.C. 7901), section 1 of the Act of July 19, 1963 (42 U.S.C. 253a), section 108 of Public Law 93-353, and titles V and XI of the Social Security Act [$557,693,000] *$637,187,000*, of which $1,200,000 shall be available only for payments to the State of Hawaii for care and treatment of persons afflicted with leprosy: *Provided*, That any amounts received by the Secretary in connection with loans and loan guarantees under title XIII and any other property or assets derived by him from his operations respecting such loans and loan guarantees, including any money derived from the sale of assets, shall be available to the Secretary without fiscal year limitation for direct loans and loan guarantees, as authorized by said title XIII, in addition to funds specifically appropriated for that purpose: *Provided further*, That this appropriation shall be available for payment of the costs of medical care, related expenses, and burial expenses, hereafter incurred, by or on behalf of any person who has participated in the study of untreated syphilis initiated in Tuskegee, Alabama, in 1932, in such amounts and subject to such terms and conditions as prescribed by the Secretary of Health, Education, and Welfare, and for payment, in such amounts and subject to such terms and conditions, of such costs and expenses hereafter incurred by or on behalf of such person's wife or offspring determined by the Secretary to have suffered injury or disease from syphilis contracted from such person: *Provided further*, That when the Health Services Administration operates an employee health program for any Federal department or agency, payment of the estimated cost shall be made by way of reimbursement or in advance to this appropriation: *Provided further*, That in addition, [$26,671,000] *$39,121,000* may be transferred to this appropriation as authorized by section 201(g)(1) of the Social Security Act, from any one or all of the trust funds referred to therein.

[For an additional amount for "Health services" for carrying out, to the extent not otherwise provided, titles III, X, and part D of title XI of the Public Health Service Act and sections 602, 604, and 605 of Public Law 94-63, $437,013,000.]

Explanation of Language Changes

1/ Authority under Title X of the Public Health Service Act had expired at the end of 1975 and was not extended until too late to be included in the Conference Bill. However, funds were made available under the extended authority in the Supplemental Appropriation.

Amounts Available for Obligation 1/

	1976 2/	1977
Appropriation	---	$697,187,000
Enacted supplemental appropriation	437,013,000	---
Conference Action	561,093,000	---
Subtotal, adjusted appropriation	998,106,000	697,187,000
Comparative transfers to:		
"Department of Transportation": for transfer of Coast Guard medical services program	-8,498,000	
"General Departmental Management": for the transfer of long-term care and related Title XVIII activities	-350,000	
"Office of the Assistant Secretary for Health": to support the establishment of safety management function in the regional offices	-23,000	
"General Departmental Management": for the transfer of budget services to the regions	-7,000	
Comparative transfers from:		
"Indian Health Services": to support decentralization of Parklawn personnel office	+61,000	
Receipts and reimbursements from:		
"Federal funds"	24,842,000	25,076,000
"Trust funds"	26,671,000	39,121,000
"Non-Federal funds"	1,274,000	1,217,000
Unobligated balance, start of year	21,134,000	1,592,000
Unobligated balance, end of year	-1,592,000	-1,592,000
Total, obligations	1,061,618,000	762,601,000

1/ Excludes the following amount for reimbursable activities carried out by this account: 1976-$6,946,000 and 36 positions; 1977-$6,854,000 and 36 positions.

2/ Includes $103,159,000 proposed for rescission in Presidential message.

Summary of Changes

1976 Estimated obligations	$1,061,618,000
1977 Estimated obligations	762,601,000
Net change	-299,017,000

	1976 Base Pos.	1976 Base Amount	Change from Base Pos.	Change from Base Amount
Increases:				
A. Built-in:				
1. 1976 Annualization of October 1975 pay raise...	---	8,643,000	---	+1,780,000
2. Annualization of 150 new positions authorized in 1976	150	2,471,000	---	+2,471,000
3. Within grade and longevity increases	---	99,681,000	---	+2,722,000
4. Increase in employee benefits.....	---		---	+37,000
5. Increase for DHEW Working Capital Fund.....	---	1,211,000	---	+271,000
6. Increase for HSA Service and Supply Fund.....	---	856,000	---	+157,000
7. Increase for Federal Telecommunications System....	---	1,138,000	---	+140,000
8. Increase for Bureau of Employee compensation....	---		---	+82,000
9. Increased rates for postage, utilities and miscellaneous rates.....	---	6,070,000	---	+551,000
10. Increases for contract medical care, services, supplies and equipment...	---	42,983,000	---	+3,738,000
11. Increased cost of operations of reimbursable health units.....	---	6,224,000	---	+177,000
Subtotal.....				+12,126,000
B. Program:				
Community health services: (a) National health service corps - $1,800,000 to fund 50 previously unfilled 1976 positions at full-year cost to serve 75,000 additional people and $910,000 to replace 72 interns with board eligible physicians to increase retention (18% to 45%)	701	20,000,000	---	+2,710,000

	1976 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Quality assurance:				
(b) Professional standards review organizations - increase will provide for 48 positions and related costs of $650,000; allow for 83 new planning PSROs; and 4 new State councils	173	47,582,000	+48	+14,220,000
Program management - support expansion of Corps field sites	941	30,663,000	+10	+200,000
Subtotal			+58	+17,130,000
Total increases			+58	+29,256,000
Decreases:				
A. Built-in:				
1. One day less pay	---		---	-286,000
2. PHS hospital repair and modernization projects-non-recurring	---	13,815,000	---	-13,815,000
3. Termination of funding for EMS research grants -authorization expires.	---	3,925,000	---	-3,925,000
Subtotal			---	-18,026,000
B. Program:				
Community health services:				
(a) Community health centers - reduction of 97 projects of 234 and a reduction of 564,000 people served	---	196,648,000	---	-41,458,000
(b) Comprehensive health grants to States-elimination of program	63	90,000,000	-63	-90,000,000
(c) Maternal and child health				
(1) Grants to States-eliminates 75 of 280 program of projects and a reduction of 30% of people served	58	295,700,000	---	-101,778,000

	1976 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
(2) SIDS - elimination of program.....	16	2,500,000	---	-2,500,000
(3) Research and training - Phase out of 10 pediatric centers; eliminates 5 University affiliated centers and terminates 19 of 93 research projects...	---	23,708,000	---	-4,208,000
(d) Family planning - terminates 760 clinics of 3,600 and reduces 451,000 persons from 2,200,000...	---	100,615,000	---	-21,180,000
(e) Migrant health - elimination of 8 operational projects from 105 and 7 developmental projects resulting in a reduction of services to 46,000 persons from 399,000.....	---	25,000,000	---	-5,800,000
(f) Health maintenance organizations:				
(1) Grants and contracts-Reduction in obligations of funding for rural HMOs.....	---	15,727,000	---	-727,000
(2) Program support-Absorption of mandatories results in a reduction of 8 manyears.....	129	3,612,000	---	-187,000
(g) National health service corps-Reduction of 25 positions providing services to 31,500 people and 10 communities..	701	20,000,000	-25	-825,000
(h) Hypertension - elimination of program.....	---	3,750,000	---	-3,750,000
(i) Home health services - elimination of program..	---	3,000,000	---	-3,000,000
(j) Hemophilia - elimination of program.....	---	3,000,000	---	-3,000,000
Quality assurance:				
(a) Medical care standards-decrease for ESRD activities; including the Medical Information Center, and absorption of $112,000 for mandatories resulting in a reduction of project contracts and other services.....	170	5,187,000	---	-1,112,000

	1976 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Patient care and special health services:				
(a) Patient care - closure or transfer to community use of 8 hospitals	5,479	136,056,000	-566	-18,290,000
(b) Federal employee health- Reduction in cost of administrative program	267	6,830,000	---	-42,000
Emergency medical services- Reduction in grants for development of EMS systems	---	33,100,000	---	-8,000,000
Program management- Absorption of mandatories results in a decrease of $940,000 and 43 manyears; $355,000 for project contracts for Community Health Center program improvement activities; $230,000 for other services for the Bureau of Medical Services; and $875,000 for rental payments to GSA	941	30,663,000	---	-2,400,000
Subtotal			-654	-310,247,000
Total decreases			-654	-328,273,000
Net change			-596	-299,017,000

Obligation by Activity*

e	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Community health services:								
a) Community health centers.....	---	155,190,000	---	196,648,000	---	155,190,000	---	-41,458,000
b) Comprehensive health grants to States.....	---	67,500,000	63	90,000,000	---	---	-63	-90,000,000
c) Maternal and Child Health:								
1) Grants to States.....	58	205,522,000	58	295,700,000	58	193,922,000	---	-101,778,000
2) SIDS.....	10	200,000	10	2,500,000	10	---	---	-2,500,000
3) Research & Training.....	---	18,600,000	---	23,708,000	---	17,500,000	---	-6,208,000
Subtotal...	68	224,322,000	68	321,908,000	68	211,422,000	---	-110,486,000
d) Family planning.....	---	79,435,000	---	100,615,000	---	79,435,000	---	-21,180,000
e) Migrant Health	---	19,200,000	---	25,000,000	---	19,200,000	---	-5,800,000
f) Health maintenance organizations:								
1) Grants and contracts ...	---	15,727,000 (15,000,000)	---	15,727,000 (15,000,000)	---	15,000,000 (15,000,000)	---	-727,000 (---)
2) Program support.....	129	3,612,000	129	3,612,000	129	3,612,000	---	---
Subtotal, Obligations	129	19,339,000 (18,612,000)	129	19,339,000 (18,612,000)	129	18,612,000 (18,612,000)	---	-727,000 (---)
g) National health service corps...	551	17,529,000 (12,529,000)	701	20,000,000 (15,000,000)	676	24,529,000 (24,529,000)	-25	+4,529,000 (+9,529,000)
h) Hypertension ...	---	---	---	3,750,000	---	---	---	-3,750,000
i) Home Health services	---	---	---	3,000,000	---	---	---	-3,000,000
j) Hemophilia	---	---	---	3,000,000	---	---	---	-3,000,000
Subtotal, Obligations	748	582,515,000 (576,788,000)	961	783,260,000 (777,533,000)	873	508,388,000 (508,388,000)	-88	-274,872,000 (-269,145,000)
Quality Assurance:								
a) Medical care standards	170	4,187,000	170	5,187,000	170	4,187,000	---	-1,000,000

Obligation by Activity*

e .	1976 Revised President's Budget Pos.	Amount	1976 Appropriation Pos.	Amount	1977 Estimate Pos.	Amount	Increase or Decrease Pos.	Amount
b) Professional standards review organ...	173	47,582,000	173	47,582,000	221	62,000,000	+48	14,418,000
		(26,448,000)		(26,448,000)		(27,066,000)		(+618,000)
Subtotal, Obligations ..	343	51,769,000	343	52,769,000	391	66,187,000	+48	+13,448,000
		(26,448,000)		(26,448,000)		(27,066,000)		(+618,000)
Patient care and special health services:	4,801		5,479		4,913		-566	
a) Patient care ..		120,333,000		136,056,000		125,056,000		-11,000,000
		(105,164,000)		(116,164,000)		(105,164,000)		(-11,000,000)
c) Federal employee health	267	6,830,000	267	6,830,000	267	7,007,000		+177,000
		(606,000)		(606,000)		(606,000)		(---)
d) Payment to Hawaii		---		---		---		---
		1,200,000		1,200,000		1,200,000		---
Subtotal, Obligations ..	5,068	128,363,000	5,746	144,086,000	5,180	133,263,000	-566	-10,823,000
		(106,970,000)		(117,970,000)		(106,970,000)		(-11,000,000)
Emergency medical services		---		---		---		
		25,100,000		37,025,000		25,100,000		-11,925,000
Buildings and facilities		---		---		---		---
		13,815,000		13,815,000		---		-13,815,000
		(---)		(---)		(---)		(---)
Program management	941	29,663,000	941	30,663,000	951	29,663,000	+10	-1,000,000
Total Obligations ..	7,100	831,225,000	7,991	1,061,618,000	7,395	762,601,000	-596	-299,017,000
		(764,969,000)		(989,639,000)		(697,187,000)		(-292,452,000)

* Where budget authority differs from obligations, budget authority is shown in parentheses.

Obligations by Object

	1976 Estimate	1977 Estimate	Increase or Decrease
Total number of permanent positions	7,991	7,395	-596
Full-time equivalent of all other positions	450	441	-9
Average number of all employees	7,712	7,482	-230
Personnel compensation:			
Permanent positions	$105,421,000	$104,215,000	$-1,206,000
Positions other than permanent	4,985,000	5,187,000	+202,000
Other personnel compensation	6,957,000	7,159,000	+202,000
Special personal services payments	375,000	375,000	---
Subtotal, personnel compensation	117,738,000	116,936,000	-802,000
Personnel benefits	22,788,000	22,816,000	+28,000
Benefits for former personnel	---	---	---
Travel and transportation of persons	4,575,000	4,370,000	-205,000
Transportion of things	1,998,000	1,717,000	-281,000
Rent, communications and utilities	9,741,000	8,085,000	-1,656,000
Printing and reproduction	916,000	868,000	-48,000
Other services	33,519,000	23,460,000	-10,059,000
Project contracts	50,442,000	63,323,000	+12,881,000
Supplies and materials	17,260,000	14,615,000	-2,645,000
Equipment	5,303,000	4,731,000	-572,000
Lands and structures	7,022,000	---	-7,022,000

Obligations by Object

	1976 Estimate	1977 Estimate	Increase or Decrease
Investments and loans.....	---	---	---
Grants, subsidies and contributions.....	790,516,000	501,880,000	-288,636,000
Subtotal.....	1,061,818,000	762,801,000	-299,017,000
Deduct quarters and subsistance charges (-).	-200,000	-200,000	---
Total obligations by object.....	1,061,618,000	762,601,000	-299,017,000

Significant Items in House and Senate Appropriations Committee Reports

Item	Action Taken or to be Taken
1976 House Report	
Community Health Services	
1. The Committee expects a report from the Health Services Administration prior to the hearings on the 1977 budget on the steps it has taken to improve the management of its programs as well as the steps taken to improve reimbursements from third party sources, with special emphasis on the maternal and child health program.	A report will be furnished to the Committee prior to the fiscal year 1977 budget hearings.
Patient Care and Special Health Services	
2. The Committee directive that there be no reduction in the 1975 position level and that the employment ceiling be raised to permit the hospitals to render services at a level and range comparable to the January 1, 1973 level in accordance with the provisions of Public Law 93-155 (page 16).	The operating ceiling for 1976 was set at 5,479, the same as the number of positions in 1975 and the 1976 Continuing Resolution. Distribution of the full ceiling was made November 28, 1975.

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1976 Senate Report

Maternal and Child Health

1. The Committee noted that the 160 MCH staff positions assigned to the maternal and child health program be filled and that both regional and central office personnel be maintained as identifiable units, devoting 100 percent of their time to maternal and child health service activities.	No action has been taken to carry out the Senate directive. Such action would require a reorganization of BCHS Central Office and each of the 10 HEW Regional Offices, since they are organized on a 'functional' basis rather than a 'categorical' basis. To provide clarity to the request, the 1977 budget specifically identifies the activity of these 160 MCH positions, although they are located and funded in 2 budget activities -- MCH grants to States (68, of which 58 are MCH and 10 SIDS), and program management (102 for MCH).

Significant Items in House and Senate Appropriations Committee Reports

Item	Action Taken or to be Taken
1976 Senate Report	
Patient care and special health services	
2. The Committee directive for the Secretary to submit within six months following enactment of the bill a report certifying that the Department is in compliance with Section 818 of Public Law 93-155 or setting out the specific steps which must be taken before he can give such certification (page 29).	The Health Services Administration will develop this report for the Secretary to submit to Congress to arrive within six months following enactment.
Program Management	
3. The Committee noted its concern that staffing (positions and cost) for many Health Services Administration categorical programs were hard to determine.	The fiscal year 1977 budget includes separate identification for categorical programs in the program management narrative justification. It specifically identifies the estimates for all categorical programs not otherwise identified in other budget activity estimates.
1976 Conference Report	
Patient care and special health services	
1. The conferees direct the Secretary to submit to Congress a report either certifying that the Department is in compliance with Section 818 of P.L. 93-155 or setting out specific steps before he can give such certification.	The Health Services Administration will develop this report for the Secretary to submit to Congress.

Authorizing Legislation

	Amount Authorized	1977 Budget Request
Community health services:		
a) Community health centers	$240,000,000	$155,190,000
b) Comprehensive health grants to states	125,000,000 1/	--
c) Maternal and child health:	350,000,000 2/	
1) Grants to states		193,922,000
2) SIDS	3,000,000	--
3) Research and training		17,500,000
d) Family planning	182,500,000	79,435,000
e) Migrant health	44,000,000	19,200,000
f) Health maintenance organizations		
1) Grants and contracts	85,000,000	15,000,000
2) Program support	Indefinite	3,612,000
g) National health service corps	3/	24,529,000
h) Home health services	4/	--
i) Hemophilia		
1) Treatment centers	4,000,000	--
2) Blood separation center	5,000,000	--
Quality assurance:		
1) Medical care standards	Indefinite	4,187,000
2) Professional standards review organizations	Indefinite	87,082,000
Patient care and special health services:		
1) Patient care	Indefinite	105,164,000
2) Coast guard medical services	Indefinite	--
3) Federal employee health	Indefinite	606,000
4) Payment to Hawaii	Indefinite	1,200,000
Emergency medical services	3/	25,100,000
Building and facilities	Indefinite	--
Program management	Indefinite	29,663,000

1/ This authorization includes $15,000,000 for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension.
2/ Authorization for all programs under Title V, Social Security Act, is $350,000,000.
3/ Authorization expires June 30, 1976. Extension legislation is proposed.
4/ This program was authorized for 1976 only at a level of $10,000,000.

Health Services

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1967	$242,521,000	$242,271,000	$242,271,000	$242,271,000
1968	410,599,000	383,406,000	384,209,000	383,806,000
1969	513,476,000	454,847,000	457,847,000	456,347,000
1970	453,507,000	461,297,000	463,207,000	463,207,000
Trust fund transfers	4,320,000	4,320,000	4,320,000	4,320,000
1971	519,798,000	519,798,000	525,940,000	521,248,000
Trust fund transfers	4,320,000	4,320,000	4,320,000	4,320,000
1972	652,219,000	656,237,000	697,118,000	667,687,000
Trust fund transfers	3,112,000	3,112,000	3,112,000	3,112,000
1973	689,915,000	735,155,000	828,657,000	735,155,000
Trust fund transfers	7,237,000	7,237,000	7,237,000	7,237,000
1974	812,456,000	812,456,000	855,806,000	918,624,000
Trust fund transfers	20,551,000	20,551,000	20,551,000	20,551,000
1975	911,683,000	919,562,000	946,157,000	946,157,000
Trust fund transfers	32,694,000	32,694,000	32,694,000	32,694,000
1976	418,315,000	545,218,000	551,835,000	549,226,000
Supplemental	266,354,000	432,013,000	440,013,000	437,013,000
Trust fund transfers	26,321,000	26,321,000	26,321,000	26,321,000
1977	697,187,000			
Trust fund transfers	39,121,000			

Justification

Health Services

General Statement

The primary objectives of the Health Services Administration are to provide health services for the underserved or disadvantaged, to build health services delivery capacity in medically underserved areas, to assure the quality of health care, to foster effective and efficient health services delivery, and to provide services to statutorily defined populations. In fiscal year 1977 the Health Services Administration will continue to emphasize these goals through efforts to improve project management, including a focus on the quality of care provided, and efforts to maintain third-party reimbursements in its project grant programs.

The programs administered by the Bureau of Community Health Services have fundamental interests in the maintenance and extension of health service capacity in order to resolve problems of access to health care. they provide a mechanism for meeting the special health needs of people who have difficulty in gaining access to care.

The Bureau of Community Health Services staff will place continued emphasis on improving project management and maintaining third-party reimbursements. The program indicators and reporting requirements will continue to be emphasized as they have produced, and will continue to produce, improved project management and decreases in the annualized costs per persons served. This is necessary in order to maintain existing health care services to the extent possible. This effort is particularly significant for the people currently being served in Community health centers, family planning projects, and migrant health projects.

The national concerns about the quality of health care have resulted in the implementation of the Professional Standards Review Organization (PSRO) program, the End Stage Renal Disease program, and other quality assurance activities within the Health Services Administration. PSRO's provide a mechanism for professional control over the inappropriate utilization of health services and for monitoring of medical practice. This should lead to improvements in the quality of care rendered to all consumers.

The Bureau of Medical Services will continue to provide health care to American seaman, Public Health Service Commissioned Corps, the other statutory recipients. However, due to a long term decrease in patient load and to other factors, legislation will be submitted to permit the transfer to community use or the closure of the eight Public Health Service general hospitals.

In response to the fact that health care needs vary from State to State, and to the fact that State and local officials rather than Federal officials are in the best position to discern those needs, several formula and project grant programs within the Health Services Administration are proposed to be merged with other health planning and health services programs in other agencies into a single health block grant in 1977. The affected Health Services Administration programs are Community Health Services, Maternal and Child Health Services, Family Planning, Migrant Health, Emergency Medical Services, and the special payment to the State of Hawaii for the care of persons with Hansen's disease. The funding levels requested for these programs in this budget are designed to provide continuity while the necessary changes in legislation are being sought.

Community Health Services

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Community Health Centers ..	---	$155,190,000	---	$196,648,000	---	$155,190,000	---	-$41,458,000
Comprehensive Health Grants to States	---	67,500,000	63	90,000,000	---	---	-63	-90,000,000
Maternal and Child Health	68	224,322,000	68	321,908,000	68	211,422,000	---	-110,486,000
Family Planning	---	79,435,000	---	100,615,000	---	79,435,000	---	-21,180,000
Migrant Health	---	19,200,000	---	25,000,000	---	19,200,000	---	-5,800,000
Health Maintenance Organizations ...	129	19,339,000	129	19,339,000	129	18,612,000	---	-727,000
Budget Authority	---	(18,612,000)	---	(18,612,000)	---	(18,612,000)	---	(---)
National Health Service Corps	551	17,529,000	701	20,000,000	676	24,529,000	-25	+4,529,000
Budget Authority	---	(12,529,000)	---	(15,000,000	---	(29,000)	---	(+9,529,000)
Hypertension	---	---	---	3,750,000	---	---	---	-3,750,000
Home Health Services ..	---	---	---	3,000,000	---	---	---	-3,000,000
Hemophilia .	---	---	---	3,000,000	---	---	---	-3,000,000
Total	748	582,515,000	961	783,260,000	873	508,388,000	-88	-274,872,000
		(576,788,000)	---	(777,533,000)	---	(508,388,000	---	(-269,872,000)

Introduction

The Bureau of Community Health Services programs have fundamental interests in the extension of service capacity in order to resolve problems of access to health care. They provide a mechanism for meeting special health needs of people in various regions, for meeting those needs considered to be of national significance and for developing and initially supporting new health services programs. It is recognized, however, that these health services needs vary among populations in different sections of the country. State and local governments are better able to determine the priority needs of their constituencies than is the Federal government. For this reason, a number of Community Health Services programs are proposed to be consolidated into a block grant to States beginning in fiscal year 1977. The Community Health Services programs foster a comprehensive approach to health care services with special emphasis on reaching underserved segments of the population. As part of the Health Services Administration, the Bureau's activities are coordinated with programs serving statutorily defined populations, the Indian Health Service and the Federal Health Programs Service. Its efforts in maintaining service effectiveness are related to the programs of the Bureau of Quality Assurance. Most importantly, Bureau of Community Health Services' authorities are being coordinated among themselves and with other Public Health Service resources in the Health Resources Administration, Alcohol, Drug Abuse, and Mental Health Administration in order to direct concerted service efforts to the needs of neglected populations. At this time the needs of rural America are receiving priority attention through the Public Health Rural Health Initiative.

Community health center project grants help low-income persons through the provision of health care in neighborhood and family health centers. The comprehensive health grants to States assist States in establishing and maintaining adequate public health services in accordance with their priorities and goals. Maternal and child health formula grants assist States in providing health services to low-income mothers and children and to crippled children. Services provided through the formula grant program are augmented through the maternal and child health research and training programs. Family planning project grants and contracts give low-income people the opportunity to determine the number and spacing of their children. Access to health care services is provided to migrant and seasonal farmworkers and their families through health service project grants located in migrant work areas. The national health service corps provides direct health care through the placement of health personnel in areas where health manpower is scarce or non-existent.

The health maintenance organization program provides a mechanism for dealing with specific major problems in health care such as rapid inflation in medical costs, the inadequate emphasis on illness prevention and the increasing uneveness in the distribution and quality of medical care.

Community Health Centers

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants..	---	$155,190,000	---	$196,648,000	---	$155,190,000	---	-$41,458,000

The major focus of the Community Health Center's program continues to be the development of health services delivery capacity in medically underserved areas of this Nation and the continued support of ambulatory health care projects located in rural and urban medically underserved areas. Funds are used for health service capacity building through a "front-end" financing approach (i.e. start-up costs for new health delivery organizations). It is intended that they help support the development of integrated systems of care and that they serve as a catalyst for the development of new and innovative approaches.

Community Health Centers' project grants are awarded to public and private entities to assist them in meeting costs associated with the planning and development and for the continuing operation of community health centers. These projects integrate a broad range of health and social services into a single organization and assure accessible ambulatory care and incorporate sound preventive health measures. These services are provided principally to a medically underserved population of an urban or rural area designated as an area with a shortage of personal health services or a population group designated as having a shortage of such services. They are predicated on total family care and are designed to insure continuity of high quality health care.

In 1977, efforts to improve management efficiency, program effectiveness and the quality of care will continue so as to maintain high quality health care for those who live in medically underserved areas.

The 157 operational Community Health Centers and 77 rural health initiative projects provided a range of preventive, curative, and rehabilitative ambulatory services and arranged for inpatient services to an estimated 1,872,000 persons in 1976, an increase of 447,000 persons (31%) over 1975. Significant program activity has been devoted to working with health centers to enable them to improve their overall management capabilities. Priority has been placed on strengthening financial management to increase third party reimbursement levels from 20 percent of total operating costs in 1975 to 22 percent in 1976.

The introduction of ambulatory health care standards and the development of project specific action plans responsive to external quality of care audits have enabled the centers to develop and maintain a high level of service quality for an expanded patient load. Explicit program expectations were implemented for all centers using already defined program reporting requirements. These program indicators and funding criteria permitted continued improvement for project funding decisions in 1976. Improvements in project management by judicious application of the Program Indicators and Funding Criteria resulted in an overall decrease of 23 percent in the annualized total cost per person served by the centers (from $204 in 1975 to $157 in 1976). Data reported in the 1974 Statistical Abstract of the United States for the total population indicate that the National per capita cost is $214 for services which are most comparable to those delivered in Community Health Centers.

Impact of 1977 Budget: The 1977 budget level will provide support to 137 projects serving 1,308,000 persons. This represents a reduction of 20 Community Health Centers and 77 rural health initiative projects and 564,000 people served in 1976. Funds in this request will be included in the proposed block grant for health. This block grant program would permit States and local governments to allot funds to the highest priority health service needs, as determined by them.

The following table illustrates the impact of the 1977 Budget:

	1975 Actual	1976 Conference Action	1977 Estimate
I. Budget Data			
Budget Authority	$196,648,000	$196,648,000	$155,190,000
On-going CHCs	$187,448,000	$190,123,000	$155,190,000
RHIs	$7,200,000	$6,525,000	---
Supplemental and other Projects	$2,000,000	---	---
II. Workload Data			
Total Projects	204	234	137
Estimated Service Population Base	5,655,000	5,955,000	5,955,000
Number of Persons Served	1,425,000	1,872,000	1,308,000
Number of Encounters	6,555,000	7,881,000	6,016,800
Cost Per Person Served all grant funds	$138	$105	$119
Cost per Encounter all grant funds	$30	$25	$26
Estimated Third-Party Patient Receipts			
CHCs	$62,000,000	$65,428,000	$54,000,000
Estimated Support from other sources (States, Foundations)	$32,000,000	$32,000,000	$28,000,000
Total Estimated Support	$290,648,000	$294,076,000	$237,190,000
Total Estimated Cost per person served	$204	$157	$181

Summary: The 1977 budget level will provide for continuity of this program at approximately the same level as the 1976 President's Budget, until such time as the Congress has had the opportunity to act upon the block grant legislative proposal.

Comprehensive Public Health Grants to States

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants.	---	$67,500,000	63	$90,000,000	---	---	-63	-$90,000,000

Comprehensive Public Health Grants to States are awarded to State health and mental health authorities on a formula basis to assist in meeting the costs of providing comprehensive public health services in accordance with priorities and goals established by the States and local governments. The program provides support for comprehensive public health services for both the general population of the States and for high risks groups, in such areas as alcoholism, cancer, chronic disease, communicable disease control, dental health, environmental health, heart disease, home health, and mental health. Data indicates that approximately four percent of all State health department budgets are supported by 314(d) funds.

Impact of 1977 Budget: No funds for this program are requested in Fiscal Year 1977. Instead, a block grant totalling $10 billion will be awarded to States to fund, at the discretion of the States, activities such as those which previously were supported under the Comprehensive Public Health Grants to States program. The following table illustrates the impact of the 1977 Budget:

	1975 Actual		1976 Conference Action		1977 Estimate	
I. Budget Data:	Pos.	Amount	Pos.	Amount	Pos.	Amount
Budget Authority:	63	$90,000,000	63	$90,000,000	---	---
II. Workload Data						
Program areas supported with 314(d) funds:						
Personal health..	50%		50%		---	
General health care and preventive services.....	28%		28%		---	
Communicable disease.....	13%		13%		---	
Chronic disease..	6%		6%		---	
Maternal and child Health.....	1%		1%		---	
Other.....	2%		2%		---	

	1975 Actual		1976 Conference Action		1977 Estimate	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Environmental Health.....	14%		14%		---	
General environmental....	6%		6%		---	
Consumer protection.....	2%		2%		---	
General sanitation.....	1%		1%		---	
Radiation control.....	1%		1%		---	
Other.....	4%		4%		---	
Health resources.....	1%		1%		---	
Other programs and administration	11%		11%		---	
Funds to Local health departments not allocable to program areas .	9%		9%		---	
Mental health activities	15%		15%		---	

Maternal and Child Health

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Subactivities:								
(1) Grants to States (Section 503, 504, and 516).....	58	$205,522,000	58	$295,700,000	68	$193,922,000	+10	-$101,778,000
(2) Sudden Infant Death Syndrome (Title XI).....	10	200,000	10	2,500,000	---	---	-10	-2,500,000
(3) Research (Section 512) and Training (Section 511)	---	18,600,000	---	23,708,000	---	17,500,000	---	-6,208,000
Total.....	68	224,322,000	68	321,908,000	68	211,422,000	---	-110,486,000

The Title V maternal and child health and crippled children programs enable each State to extend and improve services for promoting the health of mothers and children, reduce infant mortality and prevent morbidity. In addition to providing services and managing care for severely handicapped

children, standards of care are developed, facilities are licensed, clinical research findings are implemented, and health professionals are trained. The program is also designed to develop and improve services for locating and diagnosing children who suffer from crippling diseases or potentially crippling conditions and providing them with medical care, and habilitating them to become productive members of society. These purposes and goals are achieved through a network of existing State and local health agencies funded through a State formula grant program for maternal and child health and for crippled children services and through project grants for research and training. Under Title XI of the PHS Act, an information dissemination program is administered relating to sudden infant death syndrome.

Impact of 1977 Budget:

- The 1977 program funding will be provided as part of a block grant, giving States the option to fund those maternal and child health activities which they perceive as most needed.
- The 1977 budget request provides $193,922,000 for Grants to States and $17,500,000 for Research and Training.
- The amount requested for Grants to States represents a $101,778,000 decrease below the 1976 operating level.
- The 1977 request for Grants to States will significantly impact on the Crippled Children's program. Services will be reduced by approximately 30% below the 1976 level.

- Ten pediatric pulmonary centers currently are providing specialized training to 109 health professionals and services to 30,000 children suffering from such illnesses as asthma, chronic bronchitis and cystic fibrosis.
- The Maternal and Child Health Research and Training program currently is supporting 21 University-affiliated training centers, nurse-practitioner and midwife training programs for 551 health professionals, and 93 research activities concerned with improving the effectiveness of comprehensive health care programs for the advancement of maternal and child health and crippled children services.
- The Sudden Infant Death Syndrome program includes 24 projects, which provide counseling services to potentially 3,350 families, and collect SIDS related research data provided by pathology reports from autopsies.
- In 1976, the Maternal and Child Health program also provided project grants in certain highly specialized areas as described below. The problems impact differently among the States' populations. Accordingly, States are in a better position than the Federal government to decide the significance of these activities upon their populations. Therefore, beginning in 1977 these activities may be funded, at the option of each State, from health block grant monies.
- There are 68 positions in the 1977 budget, which support the Maternal and Child Health programs, in addition to the 102 positions in Program Management.

The following table reflects the impact of the 1977 Budget:

	(Non-add Columns)		
	1975 Actual	1976 Conference Action	1977 Estimate
Grants to States: Services provided to the following numbers of people:			
Mothers receiving prenatal and post-natal care	600,000	555,000	405,000
Infants admitted for Comprehensive services	166,000	153,550	112,000
Children registered for Comprehensive services	1,805,000	1,669,625	1,218,800
Women receiving nursing services	1,968,000	1,820,400	1,328,900
Children receiving nursing services	3,063,000	2,833,275	2,068,300
Children receiving dental treatment	984,000	910,200	664,450
Children screened:			
Visual screening	9,846,000	9,107,550	6,648,500
Audiometer testing	6,564,000	6,071,700	4,432,350
Dental screening	3,282,000	3,035,850	2,216,200
Children immunized (Including boosters and revaccinations):			
Polio	3,008,000	2,782,400	2,031,200
Rubella	3,282,000	3,035,850	2,216,200
Diptheria	3,282,000	3,035,850	2,216,200
Crippled children receiving physician services	550,000	508,750	371,390

Decrease in numbers served below 1975 reflects impact of an inflation rate of 7.5% per annum.

Summary: The 1977 budget level will provide for continuity of this program at approximately the same level as the 1976 President's Budget, until such time as the Congress has had the opportunity to act upon the block grant legislative proposal.

Family Planning

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Subactivities:								
(1) Family planning services...	---	$75,135,000	---	$94,500,000	---	$75,135,000	---	-$19,365,000
(2) Training and education..	---	2,300,000	---	3,600,000	---	2,300,000	---	-1,300,000
(3) Services delivery improvement.---		2,000,000	---	2,515,000	---	2,000,000	---	-515,000
Total.....	---	79,435,000	---	100,615,000	---	79,435,000	---	-21,180,000

Family planning services are designed to provide educational, comprehensive medical and social services to enable individuals to freely determine the number and spacing of their children. In providing these services priority is given to those who cannot afford them. Title X of the PHS Act authorizes funds for the support of family planning services, training of family planning personnel, development and distribution of family planning educational materials, and operational research and technical assistance to improve the delivery of family planning services.

Impact of 1977 Budget. The 1977 budget level will provide support to 2,840 projects serving 1,748,000 persons. This represents a reduction of 760 sites and 450,600 people served in 1976. Funds in this request will be included in the proposed block grant for health. This block grant program would permit States and local governments to allot funds to the highest priority health service needs, as determined by them.

The following table illustrates the impact of the 1977 Budget:

	1975 Actual	1976 Conference Action	1977 Estimate
Service grants	$94,500,000	$94,500,000	$75,135,000
Training and education	(3,600,000)	(3,600,000)	(2,300,000)
Training grants	2,000,000	2,000,000	1,000,000
Training contracts	1,000,000	1,000,000	1,000,000
Education and information contracts	600,000	600,000	300,000
Service delivery improvement contracts	2,515,000	2,515,000	2,000,000
Total	100,615,000	100,615,000	79,435,000
Number of Federally assisted family planning programs and/or clinics	3,600	3,600	2,840
Number of patient medical visits to Federally-assisted projects and/or clinics	3,600,000	3,600,000	2,798,744
Number of persons enrolled in Federally-assisted family planning projects and/or clinics (Title X)	2,200,000	2,200,000	1,749,359
Average cost per person served	$70.00	$71.00	$71.00
Number of family planning workers	46,500	46,500	45,100
Number of people trained	6,250	6,250	4,250
Pap smears	2,284,000 1/	2,284,000	1,763,000
Breast examinations	2,333,000 1/	2,333,000	1,819,183

Summary: The 1977 budget level will provide for continuity of this program at approximately the same level as the 1976 President's Budget, until such time as the Congress has had the opportunity to act upon the block grant legislative proposal.

1/ Reported by the National family planning reporting system.

Migrant Health

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants.	---	19,200,000	---	$25,000,000	---	$19,200,000	---	-$5,800,000

Projects supported under this activity provide primary health care services to migrant agricultural laborers and seasonal farmworkers and their families in order to improve and maintain the level of their health relative to that of the general population. These projects are authorized by Section 319 of the Public Health Service Act, as amended by P.L. 94-63. Services provided range from a full complement of diagnostic, therapeutic, and follow-up medical services with provisions for dental care, health counseling, preventive and outreach services to a more limited focus on specific diseases.

Impact of 1977 Budget: The 1977 budget level will provide support to 97 projects serving 353,000 persons. This represents a reduction of 8 projects and 46,000 people served in 1976. Funds in this request will be included in the proposed block grant for health. This block grant program would permit States and local governments to allot funds to the highest priority health service needs, as determined by them.

The following table illustrates the impact of the 1977 budget:

	1975 Actual	1976 Conference Action	1977 Estimate
Workload data			
Number of programs	105	112	97
Operational:			
Projects	105	105	97
Centers	--	--	--
Developmental:			
Centers	--	7	--
Potential eligible population	3,000,000	3,000,000	3,000,000
Persons served	390,000	399,000	353,000
Number of encounters	640,000	655,000	565,000
Cost per person served (from grant funds)	$61	$61	$54
Cost per encounter	$37	$37	$34
Developmental Centers - 7 each year	--	$1,500,000	--
Hospitalization Program			
Total cost	$2,256,000	$1,500,000	--
People served	3,040	1,875	--
Sanitation Program			
Project staff trained	50	60	--
State programs assistance contracts	$300,000	$450,000	--
Migrant labor housing study	--	$250,000	--
Number of projects in the referral system	15	105	97
Number of projects offering dental services	62	62	58
Number of projects with evening hours	63	85	85

Summary: The 1977 budget level will provide for continuity of this program at approximately the same level as the 1976 President's Budget, until such time as the Congress has had the opportunity to act upon the block grant legislative proposal.

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Health Maintenance Organizations

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Subactivities:								
(1) Financial assistance grants & contracts...	---	$15,727,000	---	$15,727,000	---	$15,000,000	---	-$727,000
Budget Authority..		(15,000,000)		(15,000,000)		(15,000,000)		(---)
(2) Direct Loan & loan guarantee fund 1/	---	---	---	---	---	---	---	(---)
Budget Authority..	---	(---)	---	(---)	---	(---)	---	(---)
(3) Program Support.....	129	3,612,000	129	3,612,000	129	3,612,000	---	---
Budget Authority..	---	(3,612,000)	---	(3,612,000)	---	(3,612,000)	---	(---)
Total	129		129		129		---	
Budget		19,339,000 2/		19,339,000 2/		18,612,000		-727,000
Authority..		(18,612,000)		(18,612,000)		(18,612,000)		(---)

The Health Maintenance Organization Act of 1973 (P.L. 93-222) is a Program enacted to encourage the development of health maintenance organizations as an alternative to the traditional fee-for-service delivery system. Health maintenance organizations are cost effective delivery mechanisms which provide good quality health care and provide the public with a meaningful choice in the way they receive and pay for health care. The Health Maintenance Organization Act provides for:

1. Grants and contracts for feasibility surveys.
2. Grants, contracts, and loan guarantees for planning and for initial development costs.
3. Loans and loan guarantees to cover initial operations deficits for the first three years of operations.
4. Continued regulation of HMOs qualified for participation in "dual choice" access to employer/employee health care markets.

1/ The loan fund is a revolving fund and is replenished as loans are sold to the Federal Financing Bank.

2/ This includes $727,000 which is rural set-aside funds carried over from 1975.

Impact of 1977 Budget: The table below illustrates the funding pattern to be implemented:

	1976			1977		
	No.	Average Cost	Total Cost	No.	Average Cost	Total Cost
Feasibility	32	$50,000	$1,600,000	---	---	---
Planning	21	125,000	2,627,000	24	$125,000	$3,000,000
Initial Development	15	767,000	11,500,000	15	800,000	12,000,000
Non-metropolitan area projects	(14)		(3,000,000)	(9)		(3,000,000)
	68		15,727,000 1/	39		15,000,000
Loans for Initial Operation	25	1,500,000	(37,500,000)	14	1,500,000	(21,000,000)
Program Support	---		3,612,000	---		3,612,000
Total	93		19,339,000 1/	53		18,612,000

At a grant availability of $15,000,000, selection of projects will be based on highest probability for success and will permit the new feasibility projects initiated in 1976 to be supported fully for planning (24 projects) in 1977 together with 15 development projects. The 24 planning projects will be funded at approximately $125,000 each and the 15 development projects at an average of $800,000 each.

The loan and loan guarantee fund will continue to support 27 operational projects funded in 1975 and 1976. An additional 14 operational loans will be made. The number of new loans to be placed in 1977 is based on program projections which assume that 90% of the initial development projects funded in 1976 will proceed into operations and seek and receive loan support.

For program support $3,612,000 and 129 positions are included. Program support activities include provision of technical assistance to potential health maintenance organizations and guidance in the implementation of Public Law 93-222.

Summary: The 39 planning and initial development projects to be funded plus the 14 loans for initial operations to be placed will eventually generate 50 HMOs which at maturity will have a potential of serving 1,500,000 enrollees. The Office of Health Maintenance Organization Qualification and Compliance will promote the program for qualifying HMOs seeking recognition as qualified health maintenance organizations; administer the mandatory offering of the health maintenance organization alternative in Employees Benefits Plans (dual choice) and maintain surveillance to assure continuous compliance by qualified health maintenance organizations to the requirements of the statute and regulations. 100 additional applications will be processed in 1977.

1/ Includes $727,000 in rural set-aside funds carried forward from 1975.

National Health Service Corps

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.	551	$12,487,000	701	$13,307,000	676	$15,600,000	-25	+2,293,000
Other expenses	---	5,042,000	---	6,693,000	---	8,929,000	---	+2,236,000
Total.....	551	17,529,000	701	20,000,000*	676	24,529,000	-25	+4,529,000
Budget Authority.		(12,529,000)		(15,000,000)		(24,529,000)		(+9,529,000)

The National Health Service Corps (NHSC) was established in 1971 to improve the delivery of health services to persons living in communities and areas of the United States where availability of health personnel and services is inadequate to meet health needs. To alleviate the critical health manpower shortage, the NHSC recruits and places health teams consisting of physicians, dentists, nurses, and allied health professionals in shortage areas. The NHSC seeks to improve health services in communities by providing temporary help through immediate placement of medical personnel and concurrently pursuing policies that will encourage medical professionals, once placed, to remain in the shortage areas on a non-Federal basis. But more significantly, the NHSC is very concerned with developing community capacity to plan, build, and maintain independent systems of health care, both through NHSC efforts and as a participant in the Public Health Service Rural Health Initiative.

Impact of 1977 Budget:

$24,529,000 and 676 positions will provide services to 820,500 people in 330 communities. This level requires elimination of 25 positions provided by Conference Action on the 1976 Supplemental Appropriation.

The 1977 NHSC program level will provide for improvements to be implemented within the two major program goals: community self sufficiency development and physician retention; methods of operations will also be adjusted through specific quality improvements, participation in the Rural Health Initiative, and examination of potential participation in urban areas.

Community Self Sufficiency Development - The NHSC will both refine and add to its

* The 1976 operating level includes the 1976 President's Budget level and $5,000,000 appropriated in 1975 for obligation in 1976. The Conference Action added $2,471,000 and 150 positions to the 1976 supplemental request.

efforts in assisting communities to gain the capacity to establish and independently maintain viable health practices. Pre operational and operational assistance to sites through use of management technique experts, start-up funds, and NHSC regional staff, will improve the medical record and information system, billing system, and practice and patient management systems. The structure of sites will begin to reflect a stronger emphasis on development of 2 physician and group practice rather than solo sites. Physician extenders will be used to increase physician utilization which subsequently enhances site economic viability.

New authorization permits NHSC discretionary waiver of sites' repayment of debts incurred during initial site operations. Also newly authorized is the transfer of Federal equipment to communities. Potentially, both activities could significantly enhance specific communities' conversion to independent status, such as a dental site which otherwise would have to purchase a prohibitively expensive dental operatory when approaching independence.

Physician Retention will be enhanced through improved matching by better meeting needs and desires of both communities and assignees, increasing numbers of board eligible physicians, ensuring linkages to other provider units, increasing number of 2 physician and group practice sites, and maintaining access to regional staff for support and assistance as required.

Quality Improvements - increased emphasis on comprehensive care will be reflected in increased utilization of dental services at sites; new emphasis will be placed on patients' role in preventive medicine. Quality of care assessment will be improved through implementation of organized approaches to patient and practice management systems. Continuing medical education services to assignees will be expanded by providing audiovisual capabilities to all medical sites and by establishing formal linkages with Area Health Education Centers.

Rural Health Initiative(RHI)- procedures are underway to integrate NHSC staff and resources with other programs (Community Health Centers, Family Planning, Migrant Health, Indian Health Service) to develop stronger, more effective and efficient rural health delivery systems. The RHI maximizes the self-sufficiency potential of communities and creates a professional environment very conducive to physician retention.

Urban Efforts - problems of access to medical care in urban areas will be closely examined and evaluated in terms of determining desirability and extent of Corps assistance.

The following table illustrates the impact of the 1977 budget:

	1975 Actual	1976 Conference Action	1977 Estimate
Field Strength	551	701	676
Physicians	342	450	419
Dentists	104	130	128
Physician extenders/others	105	121	129
People served	510,000	852,000	820,500
Critical Health Manpower Shortage Areas designated	1,128	1,400	1,550
Physician shortage areas	(769)	(950)	(1,050)
Sites approved[1]	445	550	650
Sites staffed	193	340	330
Independent medical sites	60	94	150
Board eligible physicians recruited	45%	65%	70%
Retention rate[2]	26%	35%	40%
Dental sites	55	100	100
Fees collected and returned to the Federal Treasury	$2,102,000	$2,700,000	$3,900,000
Non-Federal support personnel hired at sites	900	1,700	1,600
Nurse practitioners trained and placed	53	120	110
Rural Health Initiative[3]			
RHI sites	47	105	105
NHSC personnel assigned to RHI	146	315	315

Summary: The National Health Service Corps is demonstrating its capability as a cost-effective approach to achieving a permanent improvement over the existing geographic maldistribution of medical personnel. Cost projections for the next few years indicate that the average total program cost per field assignee should not exceed $37,000 per professional. Cash receipts collected from sites and returned to Treasury for services of NHSC professionals are increasing as the number of self-sustaining sites increase. In 1977, $3,900,000 from such fees should be returned to the Treasury. The program goals of community self-sufficiency and physician retention are being met as the numbers of independent sites and provider personnel remaining in communities significantly increase.

1/ Excludes independent sites.
2/ Includes medical personnel who extend on active duty as Federal employees and those who remain on non-Federal basis.
3/ Sites and personnel included in totals above.

Hypertension Programs

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants..	---	---	---	$3,750,000	---	---	---	-$3,750,000

Formula grants are awarded to State health authorities for support of hypertension programs on the basis of (1) one dollar per person up to the first 10,000 population and (2) a State's population and financial need weighted by the extent of the hypertension problem within the State, to assist in meeting the costs of establishing and maintaining programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension.

Impact of 1977 Budget: No funds are requested for grants to State health authorities for support of hypertension programs. Instead, a block grant totalling $10 billion will be awarded to States to fund, at the discretion of the States, activities such as those supported under the Comprehensive Public Health Grants to States program.

Home Health Services

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants.	---	---	---	$3,000,000	---	---	---	-$3,000,000

The Home Health Services program constitutes a medically desirable and often cost-saving alternative to institutionalized care in hospitals and nursing homes. Priority is given to areas which do not have home health services of which do not have adequate access to such services. Under Title VI of P.L. 94-63, project grants are authorized to meet initial costs of establishing new agencies or expanding existing services.

Impact of 1977 Budget: Authorization for this activity expires with the current fiscal year. No funds are requested for this program in fiscal year 1977.

Hemophilia

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants..	---	---	---	$3,000,000	---	---	---	-$3,000,000

Section 606 of Title VI of P.L. 94-63 authorizes grants and contracts for comprehensive hemophilia diagnostic and treatment centers to 1) provide services, 2) train professional and paraprofessional personnel in hemophilia diagnosis, research and treatment and 3) provide counseling for disease victims and their families.

Section 1132 of Title VI authorizes grants and contracts for projects to develop and expand within existing facilities, blood separation centers to separate, and make available for distribution, blood components to providers of blood services and manufacturers of blood fractions.

Impact of the 1977 Budget: No funds are requested for these activities in 1977. In 1976 funds were included in the first supplemental budget request but were subsequently proposed for rescission.

Quality Assurance

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Medical Care Standards....	170	$4,187,000	170	$5,187,000	170	$4,187,000	---	-$1,000,000
Professional Standards Review Organizations.....	173	47,582,000	173	47,582,000	221	62,000,000	+48	+14,418,000
Total...	343	51,769,000	343	52,769,000	391	66,187,000	+48	+13,418,000

Introduction

The Bureau of Quality Assurance provides national leadership and direction to efforts to assure that health care services provided under the Medicare, Medicaid, and other Federal programs are medically necessary and furnished in the most economical manner consistent with recognized professional standards of care, and serves as the national focus for assuring accountability to health care consumers for the quality of health care services.

The Professional Standards Review Organizations (PSROs) Program was designed to assure quality of care and to assure appropriate utilization provided to the beneficiaries of the Medicare, Medicaid and Maternal and Child Health programs.

Through the Medical Care Standards program, the Bureau provides the professional health expertise necessary for implementing the Department's responsibilities, through standards setting and enforcement, for assuring the health and safety of Medicare and Medicaid beneficiaries, including the End Stage Renal Disease program.

Medical Care Standards

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation.....	170	$3,461,000	170	$3,820,000	170	$3,573,000	---	-$247,000
Other expenses..	---	726,000	---	1,367,000	---	614,000	---	-753,000
Total.....	170	4,187,000	170	5,187,000	170	4,187,000	---	-1,000,000

The Bureau of Quality Assurance (BQA), has principal responsibility for the professional health aspects in carrying out the quality assurance provisions of Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act. As an ongoing activity, BQA provides consultation to the Social Security Administration's Bureau of Health Insurance (BHI) and the Social and Rehabilitation Service (SRS) in the process of development, interpretation, assessment, and modification of Medicare and Medicaid health and safety standards, policies, and methods for the certification of providers participating in these Federally financed programs. The standards must be continuously evaluated and revised to assure their validity, and upgraded to reflect advances in current medical care practices and technology.

Impact of 1977 Budget: A total of $4,187,000 and 170 positions is requested for this activity. This represents a decrease primarily for ESRD activities, of $1,000,000 from the 1976 level of operations.

Training activities for State Survey personnel will be supported utilizing existing central and regional staff resources and with priority being given to basic orientation and training for newly employed surveyors and limited specialized training for advanced surveyors, consultants and supervisors.

Support will be provided for the regional office standards and certification program in their monitoring and provision of consultation and training resources to 52 Medicare/Medicaid survey agencies.

The program will develop, review and revise Medicare/Medicaid provider standards, guidelines, survey procedures and forms for ten (10) categories of providers of health services: General Hospitals, Psychiatric Hospitals, Skilled Nursing Facilities, Intermediate Care Facilities, Home Health Agencies, Independent Laboratories, Out-patient Physical and Speech Therapy, Independent Practice/Out-patient Physical Therapy, End Stage Renal Disease, and Portable X-ray.

For the ESRD program the goals pursued by the Bureau would include providing assistance in setting standards, the development of guidelines and survey procedures associated with the treatment of kidney disease, and assuring the quality of covered services.

The following tables indicate the impact of the 1977 budget.

1. Table of Certified Medicare/Medicaid Providers and Suppliers -

Hospitals	
JCAH Accredited	4,861
Non-JCAH Accredited	1,905
Psychiatric	384
Skilled Nursing Facilities	7,111
Intermediate Care Facilities	8,406
Home Health Agencies	2,255
Independent Laboratories	3,089
Outpatient Physical and Speech Therapy	119
End Stage Renal Disease	725
Portable X-rays	133

2. Number of Provider Validation Surveys Conducted --

1975	1976	1977
850	850	850

3. Number of Proficiency Examinations Administered

	1975	1976	1977
Physical Therapist	62	60	0
Licensed Practical Nurse	1,331	2,000	0
Cytotechnologist	179	290	0
Clinical Laboratory Technologist	4,680	5,000	0
Psychiatric Technician	1,000	1,000	0

Summary: The Bureau would continue its ongoing activities: in the areas of health and safety standards for existing and new providers; improve laboratory services through development of uniform standards and certification procedures; implement Utilization Review (UR) regulations and a training program for State survey personnel. In addition the following activities for the ESRD program would be carried out: planning for implementation of the Medical Information System (MIS); participation in a Certification Program for facilities under the long term ESRD program; and participation in the implementation of medical review.

Professional Standards Review Organization

	1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation.....	173	$3,450,000	221	$4,015,000	+48	+$565,000
Other expenses.....	---	44,132,000	---	57,985,000	---	+13,853,000
Total.....	173	47,582,000	221	62,000,000	+48	+14,418,000

The Professional Standards Review Organization (PSRO) program was authorized by the 1972 amendments to the Social Security Act. The PSRO provision of Public Law 92-603 (Section 249F) requires the Secretary to establish and support a nationwide network of voluntary, nonprofit groups of local physicians to assure the quality and appropriate utilization of health care services financed by and provided to beneficiaries and recipients of Medicare, Medicaid, and Maternal and Child Health programs. The purpose of the statute is twofold: (a) to improve the quality of health care services; and (b) make more cost effective the expenditures for health care services financed by Title XVIII, XIX, and V of the Social Security Act. PSROs are to accomplish these purposes by applying sophisticated concepts of peer review through a system of voluntary local physician organizations, Statewide Councils, and a National Council supported and evaluated by the Federal Government.

The PSRO legislation requires PSRO review of services furnished by hospitals and other health care institutions such as skilled nursing facilities and intermediate care facilities. The review of other types of health care, such as ambulatory care, may be undertaken at the option of the individual PSRO and with the Secretary's approval.

The PSRO program relates closely to and must be integrated with other health care review activities required by the Social Security Act particularly as the Act was amended in 1972. The PSRO legislation intends that utilization review and other related duplicate review activities will eventually be eliminated and PSROs will assume responsibility for such activities.

FY 1977 Activities: PSRO activities during 1977 will allow implementation of the program in all 203 areas, thus initiating the final transition from utilization review to PSRO. Early in 1977,55 planning PSROs will be converted to conditional status for a total of 120 conditional PSROs; 83 new planning PSROs will be funded. In addition, 10 Statewide Councils will be funded and some PSROs will initiate Long-term care review. The capability of the 120 conditional PSROs to perform review of about 65-75% of the hospital admissions will be made possible through implementation of P.L. 94-182, the new financing amendment to the Social Security Act which allows non-delegated review (review performed by the PSRO) to be financed through the Trust Funds.

Program Status at End of FY 1976: By the end of 1976, 2 additional planning PSROs will have been converted to conditional status, for a total of 65 conditional PSROs. Fifty-five PSROs will remain in planning status. Six Statewide Councils will have been established. The 65 conditional PSROs will have reviewed approximately 1.9 million hospital admissions of the 11 million Medicare/Medicaid admissions.

Examples of conditional PSRO activity are as follows:

(1) The Delmarva PSRO, Eastern Maryland (converted to conditional status in July 1975) has implemented review in four out of six hospitals. As of December 1975 early statistics reveal that Medicare and Medicaid length of stay has declined substantially (.8 to 2.8 length of stay days) in three of the four hospitals over the first two months of the PSRO program in comparison with the previous two years.

(2) The Multnomah Foundation for Medical Care (MFMC) Portland, Oregon, is presently performing admission certification and continued stay review on 100% of the elective and emergency admissions covered under Titles XVIII and XIX in all 14 acute care hospitals in PSRO Area I. Recently, MFMC began review in 12 of the 17 area Skilled Nursing Facilities on a demonstration basis. Between July 1, 1975, and January [illegible], 1975, MFMC will have reviewed 16,500 acute admissions and 1,000 SNF admissions as well as 1,000 admissions for eight area insurance carriers. MFMC has a current membership of 1,103 which represents 63% of the eligible physicians in the PSRO area. In a study performed by Oregon Physicians Services, involving review of admissions in certain hospitals for the period, May 1973 to September 1974 it was shown that for every dollar invested for review, 5 were saved through reduced length of stay (costs of $6,630 vs. savings of $35,900). Average length of stay fell 1.8 percent per month, greatly exceeding national trends towards shorter lengths of stay.

(3) The Colorado Foundation for Medical Care (CFMC) is presently performing admission certification and continued stay review on 100% of the elective admissions covered under Titles XVIII, and XIX in all 91 of the acute care hospitals in the State. The current review activity is approximately 10,000 admissions per month. The Foundation has signed interim Memoranda of Understanding with the Title XVIII and XIX programs. The Foundation has a current membership of 1,719 out of an eligible population of 3,580 physicians. A preliminary analysis of review performed of Medicaid beneficiaries in Colorado during 1974 suggests a decrease in utilization of facilities by about 10%. This amounts to a savings of about 155 days per 1,000 Medicaid beneficiaries and a net savings of about $2.4 million in 1974.

(4) The Mississippi Foundation for Medical Care (MFMC) is presently performing admission certification and continued stay review on 100% of the admissions covered under Titles XVIII, XIX, and V in 56 of the 109 acute care hospitals in the State. The remaining 54 hospitals will be under review by May 1976. Since June 1, 1975, MFMC has reviewed 35,011 PSRO admissions. The current review activity is approximately 8,000 admissions per month. The Foundation has signed Memoranda of Understanding with the Title XVIII and XIX programs. A Memoranda of Understanding with the Title V program is anticipated in the near future. The Foundation has a current membership of 1,256 out of an eligible population of 3,580 physicians.

Impact of 1977 Budget: A total of $62,000,000 and 221 positions is requested for this activity. This represents an increase of $14,418,000 and 48 positions over the 1976 level. This program is funded from Social Security Trust Funds ($34,934,000) and direct appropriated funds ($27,066,000).

The 1977 budget of $62,000,000 with full implementation of the new financing amendment by the end of the year, will allow expansion of the PSRO program to cover all 203 areas. PSROs will be funded in all areas where qualified physician organizations, still interested in participating in the program, exist. Eighty-three new planning PSROs will be funded in order to

cover all 203 PSRO areas. Early in 1977 fifty-five planning PSROs will be converted to conditional status for a total of 120 conditional PSROs. These conditional PSROs will perform review of approximately 3.0 of the total 11 million Medicare/Medicaid hospital admissions and some PSROs will initiate long term care review. The 6 Statewide Councils established in 1976 will continue to be supported in 1977, and 4 new Statewide Councils will be established for a total of 10 Statewide Councils.

The 48 positions will monitor the expanded number of PSROs and will provide technical assistance in areas such as financial management, data, peer review, organization development and monitoring. General and specialty contract funds will provide necessary support to the PSROs for such activities as development of new methodologies of review in rural areas, utilization of nonphysician health care practitioners, development of review methods for long term care facilities, ambulatory care, HMOs, etc. A significant amount of contract and evaluation funds will be applied to the evaluation of the impact of the PSRO program on the quality and utilization of health care services financed under Medicare, Medicaid, and Maternal and Child Health programs. For example, the effect of concurrent review on reductions in length of stay and unnecessary admissions will be assessed as well as the impact on changes in physician behavior.

Program Plans

	1976		1977	
	No.	Amount	No.	Amount
S & E		$4,672,000		$5,520,000
Planning				
Old	55	8,240,000	---	---
New	---	---	83	10,375,000
Subtotal	55	8,240,000	83	10,375,000
Conditional				
Old	63	31,500,000	65	26,035,000A.
New	2	1,100,000	55	16,200,000
Subtotal	65	32,600,000	120	42,235,000
State Council	6	300,000	10	1,000,000
Contracts and Evaluation		1,770,000		2,879,000
Total		47,582,000		62,000,000

A. These 120 PSROs would also receive about $27 million for review activities of hospital admissions from the new financing system. The combined total of $69 million will support review of about 3 million M/M hospital admissions.

Patient Care

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	4,801	$83,301,000	5,479	$90,373,000	4,913	$88,032,000	-566	-$2,341,000
Other expenses		37,032,000		45,683,000		37,024,000		-8,659,000
Total	4,801	120,333,000	5,479	136,056,000	4,913	125,056,000	-566	-11,000,000
Reimbursable obligation		15,169,000		19,892,000		19,892,000		---
Direct Obligations		105,164,000		116,164,000		105,164,000		-11,000,000

The primary mission of this program is to provide comprehensive health care to Public Health Service beneficiaries. On a reimbursable basis, health care is also being provided in PHS hospitals and outpatient clinics to beneficiaries of other Federal agencies, including active duty military and their dependents, and to foreign seamen and community residents.

The program currently operates eight general medical and surgical hospitals, most of which have training and research programs, and the National Leprosarium at Carville, Louisiana. In addition, the system operates 26 outpatient clinics, purchases health services in four other outpatient clinics, and contracts with about 200 physicians and dentists to provide health care to ambulatory patients. When PHS facilities are not readily accessible, beneficiaries receive care in other Federal and non-Federal facilities. Training programs are established for medical and dental residents as well as for allied health personnel. Research programs include both clinical and health services research. Some clinical research is financed by grants from other Federal agencies, such as the National Institutes of Health.

This program has been operating the PHS hospitals and outpatient clinics under the legislative mandate of Section 818 of Public Law 93-155, which provides that the PHS facilities continue to furnish all patient care services at the operating level of January 1, 1975, unless Congress approves a proposed legislative change.

The 1977 budget proposes: 1) to submit to Congress legislation to authorize the transfer to community use or the closure of the eight Public Health Service general hospitals; 2) continuation of medical care to primary beneficiaries of the PHS on a contractual basis; 3) continued operation of the National Leprosarium at Carville, Louisiana and the PHS outpatient clinics; and 4) payments to participants in the study of untreated syphilis initiated in Tuskegee, Alabama, in 1932.

Closure or transfer to community use of the eight PHS hospitals is sought for the following reasons:

- Current use of the facilities is very low, an estimated 69% of capacity for 1976;
- Only 53% of patients using the hospitals are primary beneficiaries;
- The hospitals are located in areas where adequate community facilities are available to take care of current PHS patients if the PHS hospitals

were closed. This would not adversely affect the availability of adequate hospital resources to the community;

- Five of the eight PHS hospitals (Galveston, Seattle, Baltimore, Boston, and San Francisco) are in areas with an excess of hospital beds for community needs. Continued operation of PHS facilities in such areas tends to push up community hospital costs.

Impact of 1977 Budget:

The 1977 budget estimates are predicated on the transfer to community use or the closure of the eight Public Health Service general medical and surgical hospitals. Plans will have to be formulated to provide;

- Administration of a contract health care program for the beneficiaries of the Public Health Service;
- Care of beneficiaries of other Federal agencies;
- Disposition of the PHS hospitals after patients leave;
- Continuation or phasing out of community programs established under Section 328 of the PHS Act;
- For meeting commitments under current training programs within PHS facilities.

Federal Employee Health Services

	1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits	267	$4,406,000	267	$4,484,000	---	+$78,000
Other expenses	---	2,424,000	---	2,523,000	---	+99,000
Total	267	6,830,000	267	7,007,000	---	+177,000
Reimbursable obligations		6,224,000		6,401,000		+177,000
Direct obligations		606,000		606,000		---

This program provides consultation on the organization and establishment of employee health services to any Federal agency requesting advice; provides standards and criteria for the furnishing of such employee health services; and when requested, assists agencies in the evaluation of such services. The program also organizes, administers, and operates Federal employee health services for participating Federal agencies on a reimbursable basis.

The services authorized include emergency diagnosis and treatment of injury or illness occurring during working hours; inservice examinations determined necessary by the Department or agency head; administration of treatments and medications under certain circumstances; preventive health services, appraisal of work environment and health hazards; health education; specific disease screening examinations and immunizations; referral to private physicians, dentists, and other community health resources.

In 1976, 100 consultations to Federal agencies, executive boards, and associations were provided on the evaluation and establishment of Federal employee health activities. Occupational health services were provided to approximately 200,000 Federal employees in 106 health units.

Impact of 1977 Budget: The $606,000 in appropriated funds will provide for continuation of employee health activities at the 1976 level. The increase of $177,000 in reimbursable funds are for built-in items of expense.

	1975 Actual	1976 Estimate	1977 Estimate
Consultation	100	100	100
Population served	190,000	200,000	200,000
Health units (Reimbursable)	106	106	106

Summary: Based on the positions and funds reflected in the 1977 estimate, the program will continue to be responsive to Federal agencies for requested consultation and evaluation of their occupational health programs and will continue to operate 106 health units providing services to approximately 200,000 Federal employees.

Payment to Hawaii

	1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants	---	$1,200,000	---	$1,200,000	---	---

Federal legislation was passed on June 25, 1952, providing for payments to the Board of Health of the State of Hawaii for the care and treatment in its facilities of persons with Hansen's disease. Funding for this program began in F.Y. 1953 in the amount of $500,000; from F.Y. 1954 thru F.Y. 1960, $1,000,000 was appropriated each year, and since F.Y. 1961, $1,200,000 has been appropriated annually. Expenses above the Federal payment are borne by the State of Hawaii.

Impact of 1977 Budget:

- This activity will be included in the health block grant.

- Cost borne by the State of Hawaii will increase by $51,500 to $932,500.

The following table illustrates the impact of the 1977 Budget:

	1975 Actual	1976 Estimate	1977 Estimate
ADPL	137	134	131
Patient Days	49,998	48,910	47,450
Inpatient per diem cost	$39.53	$41.48	$43.82
Outpatient visits	2,154	2,348	2,583
Per visit cost	$17.42	$22.16	$20.64
Total program cost	$2,013,746	$2,080,938	$2,132,452
Appropriation request	$1,200,000	$1,200,000	$1,200,000

Emergency Medical Services

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Grants	---	$25,100,000	---	$37,025,000	---	$25,100,000	---	-$11,925,000

The Emergency Medical Services Systems Program (Title XII) provides for support by grants and contracts to assist in the development of regional EMS systems. Federal assistance provides for (1) the conduct of feasibility studies and planning, (2) establishment and initial operations, (3) expansion and improvement, and (4) research projects for the development of EMS systems.

Impact of the EMS Program

- The program works in cooperation with other health delivery programs of DHEW and other Federal agencies to interrelate improvement of the Federal investment in such areas as transportation, communications, training and education, and disaster coordination.

- The program has had an impact on bringing into the scope of EMS activities critical patient health programs to include trauma, burns, poisoning, high risk infants, heart attacks, acute psychiatric disturbances, and alcohol and drug overdose. The EMS systems are now more aware of these critical problems, how they are diagnosed and treated, and a need to create the capability to transfer patients to special treatment centers.

- A total of 124 EMS systems will have been initiated as a direct result of the EMS program. The systems in operation are having an impact on traumatic death and sudden illness.

- Each State and Territory has now established an organization to be responsible for EMS activities. Forty-four States have developed an EMS plan. Thirty-five States have enacted some type of licensure law for ambulances. Thirty-nine States now offer and/or require basic Emergency Medical Technician training for ambulance attendants.

- Although national total data are not available in the early stages of this program, significant data are available showing lives saved by critical patient groups from several of the projects:

  - Illinois (trauma) - A 29% reduction in vehicular accidental deaths.

  - Maryland (trauma) - 750 lives saved by the Trauma Center in one year.

  - Seattle (cardiac) - 85 lives saved in six months.

  - Nassau County, N.Y. (cardiac) - Decrease in death for myocardial infarction from 5.1% to 1.0%.

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- Denver (neo-natal) - Threefold increase in survival rate of prematures with respiratory disorders.

- Arkansas (poison) - 45 lives saved during a four-month period.

- New York City (drug overdose) - Threefold reduction in death rate among addicts who participate in methodone drug registry.

Impact of 1977 Budget

- The program will continue to establish and improve EMS systems throughout the Nation. (See table)

- The program emphasis will be to stress (1) the role of States and communities to configure self-sufficient EMS systems, and (2) the development of the manpower and employment profile to staff a quality EMS system.

- The 1977 budget level will provide support to 97 regional EMS systems in some phase of operation, an increase of seven systems above 1976. On a cumulative basis, funding will have been provided to support emergency medical care systems serving a population of approximately 62,000,000 persons, an increase of 2,000,000 persons above 1976. Funds in this request will be included in the proposed health block grants. This proposal is consistent with the President's view that State and local governments are in a better position to determine their needs and priorities than the Federal Government.

The following table illustrates the impact of the 1977 Budget:

	1975 Actual	1976 Estimate	1977 Estimate
Feasibility and planning:			
No. of systems funded	89	75	--
Amount	$4,875,000	$3,400,000	--
Initial operations:			
No. of systems funded	93	47	4
Amount	$19,500,000	$18,800,000	$1,700,000
Improvement:			
No. of systems funded	27	43	93
Amount	$8,125,000	$10,900,000	$23,400,000
Sub-total:			
Number	209	165	97
Amount	$32,500,000	$33,100,000	$25,100,000
Research:			
No. of grants awarded	28	25	--
Amount	$4,500,000	$3,925,000	--
Total Amount	$37,000,000	$37,025,000	$25,100,000
Number of EMS systems which have completed funding under the EMSS Act	--	10	27

Summary

The EMS Program has had a significant impact on the delivery of emergency medical care. It is estimated that 124 regional EMS systems, serving 62,000,000 persons, will have been established and improved with EMS funding. These funds have been used to assist 49 of the 50 States; the District of Columbia, Puerto Rico, Guam, and the Trust Territory of the Pacific Islands. Almost 50% of available funds will have been used to serve rural areas.

These regional EMS systems have served to promote and enhance area-wide planning and the delivery of health services. Instead of supporting fragmented and isolated services, they integrate and coordinate resources and services on a regional (area-wide) basis. In order to achieve these results, the boundaries of each region have been based on the following criteria:

- Medical self-sufficiency - ability to provide quality medical services for at least 95% of the population with appropriate linkages to other systems for the most critical patient groups (i.e., burns, spinal cord injury, and acute cardiac).

- Potential for financial self-sufficiency - ability to continue to operate after the system has completed its eligibility for Federal funding.

- Contiguous to other regions - providing services for the "have-nots" as well as the "haves."

- Categorization of facilities - to eliminate duplication, reduce costs, and increase specialization (i.e., critical care units for the critical patient groups).

The 1977 budget level will provide for continuity of these programs at approximately the same level as the 1976 President's budget, until such time as the Congress has had the opportunity to act upon the block grant legislative proposal.

Buildings and Facilities

	1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Other	---	$13,815,000	---	---	---	-$13,815,000
Budget authority	---	---	---	---	---	---

This activity includes all proposed direct construction items of the Health Services Administration except construction of Indian health facilities. The 1976 estimate provides for the continued upgrading of PHS facilities with funds appropriated in prior years. No new funds are requested.

The following illustrates the number of projects to be undertaken in 1976 by type of construction or improvement.

Category of Construction	No. of Projects	Hospitals Involved
Fire and Safety Code Deficiencies.....	31	9
Urgent Facility Repairs and Renovation.....	33	9
Joint Commission on Hospital Accreditation Requirements.....	13	5
Program Improvements.....	25	9

Impact of 1977 Budget:

- Legislation will be submitted to Congress to transfer to community use or to close the Public Health Service hospitals, excluding the National Leprosarium at Carville, Louisiana.

- As a result of the pending transfer/closure actions, no new construction funds are requested.

Program Management

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.....	941	$19,552,000	941	$19,552,000	951	$19,827,000	+10	+366,000
Other expenses....		10,111,000		11,111,000		9,836,000		-1,366,000
Total.....		29,663,000	941	30,663,000	951	29,663,000		-1,000,000
Subactivities:								
Bureau of community health services..	641	18,929,000	641	18,929,000	651	18,826,000	+10	-103,000
Bureau of medical services.....	123	3,509,000	123	3,509,000	123	3,494,000	---	-15,000
Office of the Administrator....	177	3,970,000	177	3,970,000	177	3,963,000	---	-7,000
Payment to GSA....		3,255,000		4,255,000		3,380,000		-875,000
Total.....	941	29,663,000	941	30,663,000	951	29,663,000	+10	-1,000,000

Introduction

The purpose of the program management activity is to administer and provide program support to the Bureau of Community Health Services and the Bureau of Medical Services programs, to provide for the payment of rent to the General Services Administration, and to support the Office of the Administrator which plans, directs, and administers the programs of the Health Services Administration.

For 1976 there is proposed a net decrease of $1,000,000. This consists of a decrease of $875,000 for payment to GSA which is directly related to savings anticipated due to the projected early F.Y. 1977 closure or transfer to community use of the PHS hospitals and clinics. The remaining decrease of $125,000 represents a minor reduction which will be offset by higher than normal lapse rate.

Bureau of Community Health Services

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.....	641	$13,907,000	641	$13,907,000	651	$13,804,000	+10	-$103,000
Other expenses..	---	5,022,000	---	5,022,000	---	5,022,000	---	---
Total.....	641	18,929,000	641	18,929,000	651	18,826,000	+10	-$103,000
Sub-sub-activities:								
Community health centers.....	296	8,582,000	296	8,582,000	296	8,479,000	---	-103,000
Maternal and child health....	102	3,438,000	102	3,438,000	102	3,438,000	---	---
Family planning.	110	3,005,000	110	3,005,000	110	3,005,000	---	---
Migrant health..	40	1,173,000	40	1,173,000	40	1,173,000	---	---
National health service corps...	93	2,731,000	93	2,731,000	103	2,731,000	+10	---
Total.....	641	18,929,000	641	18,929,000	651	18,826,000	+10	-103,000

Program management activities relating to Bureau activities will be reduced in 1977 in view of the proposed reduction in the grant programs. Although the funding level in 1977 will be slightly below the 1976 level, the net effect of the decrease will be more significant since no funds are requested for mandatory increases in 1977. This estimate supports continuation of both central and regional activities. The following activities have been of primary interest to each Bureau program in 1976. Many of these objectives are ongoing from year to year and others will be terminated in 1976 at their completion and replaced with other program initiatives.

Community health centers - Emphasis has been placed on obtaining third-party reimbursements to cover the twenty percent reductions proposed in the 1976 President's Budget; the expansion of service delivery capability through increased productivity and efficiency of operations; the improvement of the quality of services offered in Community Health Centers; improve program management structure in conformance with new legislative authority; and expand service delivery capability through the Rural Health Initiative.

Maternal and child health - The development of systems of reporting data for activities that will assist in monitoring and evaluating the programs for Maternal and child health activities; establish criteria for development, implementation, funding and monitoring of Maternal and child health and Crippled Children's Services State Plans; plan, develop and implement a service, education and informational program as specified in Part C, Sections 1121 of the Sudden Infant Death Syndrome Act incorporating evaluation criteria which assesses the impact of the program on SIDS bereaved families who have been recipients of project services; review and assess the Reserve B projects to assure that they are of regional and national significance and in accordance with Title V legislation and long range objectives of the Bureau of Community Health Services; develop research priorities based upon determined needs and develop and implement a strategy for the research program in accordance with these needs; develop training priorities based upon determined needs and develop and implement a strategy for the training program in accordance with these needs; offer technical assistance to fifty-six jurisdictions and gather information to improve financial management.

Family planning - Activities in this program are as follows: Implement interim reporting system; implement cost reporting requirements, a model Regional Billing System, a fee collection strategy, and strategies directed at financial management and third party reimbursements; conduct multi-media campaign and develop information and education strategy, educational material for target groups, and self-instructional materials; implement training improvement guidelines and plans and a new training management system; develop and fund service integration initiative and integrate family planning services into other BCHS projects, work settings and rural areas; implement medical care guidelines and quality assurance approach, distribute quality of care information, and conduct quality of care studies; develop and implement mechanisms for improving project performance and a long-range service improvement strategy; improve central and regional office management.

Migrant health - Continuation of the delivery of health services to migrant and seasonal farmworkers; implement programs to improve environmental sanitation and develop legislative recommendations for financing migrant labor housing; implement medical care quality improvement programs in full-time comprehensive projects; implement a national record retrieval and referral system; implement a national patient referral system in all projects; and conduct special studies, develop information program and modify program to conform to new legislative requirements.

National health service corps - Objectives of this program are as follows: The recruitment and placement of health manpower professionals; develop and approve new project sites in designated areas; monitor and assist operating sites toward financial and operational self-sufficiency. In 1976, 45 physicians, 14 dentists and 40 physician extenders will either develop independent practices or extend during the fiscal year. Further, 35 sites are anticipated to go independent and 100 are to achieve financial self-sufficiency; improve quality and coverage of service at all sites; carry out operational and administrative support requirements; designate additional areas and revalidate all designations aged two years or more; integrate National health service corps activities with other Bureau programs.

Bureau of Medical Services

	1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel compensation and benefits.....	123	$2,138,000	123	$2,637,000	---	+$499,000
Other expenses.....	---	1,371,000	---	857,000	---	-514,000
Total	123	3,509,000	123	3,494,000	---	-15,000
Sub-subactivities:						
Patient care and special health services.....	94	2,517,000	94	2,499,000	---	-18,000
Emergency medical services.....	29	992,000	29	995,000	---	+3,000
Total	123	3,509,000	123	3,494,000	---	-15,000

Introduction

The purpose of the program management activity is to administer and provide program support to the Bureau of Medical Services operating programs.

Patient Care and Special Health Services

In fiscal year 1977, program direction and management services will continue to be provided for all of the Bureau's operating programs --- the system for providing health care services for Public Health Service beneficiaries which include the continued operation of the National Leprosarium at Carville, Louisiana, and the system of PHS outpatient clinics; consulting on and surveying occupational health programs for Federal employees, including operation of Federal employee health units on a reimbursable basis; and the program for assisting regional communities in establishing emergency medical service systems.

With the plan to propose legislation to authorize the transfer to community use or the closure of the eight PHS general hospitals, special emphasis will be placed on administering a contract care program to provide hospitals services for PHS beneficiaries after closure or transfer of the PHS hospitals. Plans will also be developed and implemented for the orderly disposition of the Federally-owned PHS hospitals, upon closure or transfer to community use.

Emergency Medical Services

The 1977 budget request for this subactivity supports a staff necessary to:

- Administer the grant program for the development of a nationwide network of viable, regional emergency medical services systems;
- Provide technical assistance to grantees, prospective grantees and others as appropriate;
- Monitor projects to evaluate progress in accordance with the prescribed regulations;
- Establish program guidelines, grant review and award cycles, workshops and symposiums to disseminate program policy and guidances,

- Maintain program management continuity for an effective and economical method to achieve self-supporting regional emergency medical services systems for the population.

Office of the Administrator

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensation and benefits	177	$3,507,000	177	$3,507,000	177	$3,477,000	---	-$30,000
Other expenses....	---	463,000	---	463,000	---	486,000	---	+$23,000
Total	177	$3,970,000	177	$3,970,000	177	$3,963,000	---	-$ 7,000

Impact of 1977 Budget:

The 1976 request for this subactivity supports a central staff necessary to plan, direct, and administer the broad scope of programs and activities in the Health Services Administration. Support is provided the Administrator in the formulation of policies and program plans, and in evaluating Agency progress in mission accomplishments. Also, staff assistance is provided in the areas of contracts and grants administration, financial management, personnel management, property management, legislative services, communications and public affairs, equal employment opportunity, and general services.

Payment to GSA

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Personnel Compensation and benefits	---	---	---	---	---	---	---	---
Other expenses....	---	$3,255,000	---	$4,255,000	---	$3,380,000	---	$-875,000
Total	---	$3,255,000	---	$4,255,000	---	$3,380,000	---	$-875,000

For Payment to General Services Administration

This budget proposes $3,380,000 a reduction of $875,000. The reduction is based on the savings anticipated due to the projected early F.Y. 1977 closure or transfer to community use of the PHS hospitals and clinics.

Health services

Program Purpose and Accomplishments

Activity: Community health services -- Community health centers (PHS Act Section 330)

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$196,648,000	$240,000,000	---	$155,190,000

Purpose: The development of health services delivery capacity in medically underserved areas, the provision of high quality health services in such areas, and the use of funds for health service capacity building through a "front end" financing approach are the primary foci of the Community Health Centers Program. They integrate a broad range of health and social services into a single organization and these projects assure accessible ambulatory care and incorporate sound preventive health measures. The services are provided principally to a medically underserved population of an urban or rural area designated as an area with a shortage of personal health services or a population group designated as having a shortage of such services. Community health centers are predicated on total family care and are designed to insure continuity of high quality health care.

Explanation: Under Section 330 of the Public Health Service Act, project grants are awarded to public and private entities to assist them in meeting costs associated with the planning and development and for the continuing operation of community health centers which provide primary health care and arrange for specialty and inpatient care primarily for people in medically underserved areas where health resources are scarce or non-existent.

Accomplishments in 1976: In 1976, 157 community health centers provided a range of preventive, therapeutic, and rehabilitative ambulatory services to an estimated 1,500,000 persons. In addition, 372,000 persons were served in 77 rural health projects which were designed to build health services delivery capacity in medically underserved rural areas through the development of an integrated health services delivery system to improve the accessibility, availability and efficiency of ambulatory primary care resources in medically underserved areas. Due to improved overall management capabilities, third party reimbursements increased to 22 percent of total operating costs compared to 20 percent in 1975. The continued application of the Program Indicators and Funding Criteria resulted in improved project management and funding decision in 1976.

The analysis of the project performance using the Program Indicators for one year period indicates that the 1975 level of 2.5 primary physician encounters per hour for Community Health Centers was increased to 2.7 in 1976. The percent of total ambulatory costs that are direct ambulatory health care costs was increased to 62% in 1976 from 59% in 1975, and the percent of total ambulatory costs that are for general services and allocable costs was reduced from 30% in 1975 to 25% in 1976. Ambulatory health care standards were developed and surveys of all centers have been conducted thus enabling the centers to achieve and maintain a high level of quality services.

Objectives for 1977: Efforts to improve management efficiency, program effectiveness, and the quality of care will continue. Approximately 1.3 million persons will be served in 137 health centers. We will increase assurance of care effectiveness by the continued application of ambulatory health care standards which will be met by all Community Health Centers. This added assurance of care quality will allow major third party payors to adopt a policy of full reimbursements for services rendered by the centers to their clients. Funds in this request will be included in the proposed block grant for health.

Activity: Community health services -- Comprehensive public health grants to States (PHS Act, Section 314(d))

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
63	$90,000,000	$110,000,000	---	---

Purpose: These formula grants are awarded to State health and mental health authorities to assist in meeting the costs of providing comprehensive public health services in accordance with priorities and goals established by the States.

Explanation: Under Section 314(d) of the PHS Act, grant allocations are based on a State's population and financial need.

Accomplishments in 1976: Program areas for which these funds were used include chronic disease programs, environmental health services, laboratory services, home health and public health nursing services and community mental health services. The 63 Federal positions were utilized to supplement State staff in communicable disease control programs.

Objectives for 1977: No funds will be allocated to State public health authorities to assist in meeting the costs of providing Comprehensive health services. Instead, a health block grant totalling $10 billion will be allocated to States. The 63 Federal positions will be reduced from the Federal employment or transferred to other Federal government health programs.

Activity: Community health services. Maternal and Child health (Title V, Social Security Act as amended through 1973, Sections 503, 504, 511, 512 and 516; Title XI, PHS Act as amended, 1974).

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
68	$321,908,000	1/	68	$211,422,000

Purpose: The Title V maternal and child health and crippled children programs enable each State to extend and improve services for promoting the health of mothers and children, reduce infant mortality and prevent morbidity. In addition to providing services and managing care for severely handicapped children, standards of care are developed, facilities are licensed, clinical research findings are implemented, and health professionals are trained. The program is also designed to develop and improve services for locating and diagnosing children who suffer from crippling diseases or potentially crippling conditions and providing them with medical care, and habilitating them to become productive members of society. These purposes and goals are achieved through a network of existing State and local health agencies funded through a State formula grant program for maternal and child health and for crippled children services and through project grants for research and training. Under Title XI of the PHS Act, an information dissemination program is administered relating to sudden infant death syndrome.

Explanation: Section 503, Maternal and Child Health Services, and Section 504, Crippled Children Services, provide for grants to States on a formula basis to deliver appropriate services. Grants also are authorized to State agencies and

1/ Authorization for all programs under Title V, Social Security Act, is $350,000,000 but is indefinite by activity. Authorization for Title XI of PHS Act is $3,000,000.

public or non-profit institutions of higher learning for special projects of regional or national significance which contribute to the health of mothers and children, including crippled and mentally retarded children. In both formula grant programs, one-half of the amount appropriated for each Section is apportioned among the States on a population-related formula basis. From the remaining half of the appropriation, specified amounts are reserved for special project grants and the balance is apportioned by formula (inverse population and per capita income ratio) among the States. Section 516 provides for supplemental allocations to States for maternal and child health services to insure that no State receives less funds under the formula distribution than it did under the formula and project distribution in 1973.

Title XI, the Sudden Infant Death Syndrome program, through grant and contract arrangements, develops and disseminates informational materials to health providers and the affected public.

Section 511, Maternal and Child Health Training, and Section 512, Maternal and Child Health Research: the University-affiliated Centers program provides multidisciplinary training for specialists who will work with mothers and children, particularly mentally retarded children or those suffering from multiple handicaps. These centers have developed effective programs of prevention, treatment, and rehabilitation. Grants to public or non-profit institutions of higher learning provide support for faculty, traineeships, services, clinical facilities, and short-term institutes and workshops. At each center the faculty, representing over 20 professional disciplines, provides a full range of clinical services as well as the setting to train future professionals. Within individual centers programs are designed to meet the professional needs of the trainees, including language development and disorders of handicapped children, methods for integrating the retarded child into regular schools, and feeding clinics and workshops for nutritionists and dietitians who will work with handicapped children.

Research grants and contracts are made with research organizations and public or private non-profit agencies to conduct research concerning mothers and children in all classes of our society. High priority is given to solving special problems faced by population segments which do not receive adequate health care.

Accomplishments in 1976: Continued emphasis was focused on implementing the program of projects as authorized by P.L. 93-53. Efforts were directed toward improving financial management, data collection and cost-finding techniques. The 163 projects initiated in 1975 and the 197 previously supported under project grant authority continued to receive technical assistance to prepare them to become providers of services under insurance and public health care financing programs, e.g. Medicare and Medicaid.

Estimated Numbers of People Served in 1976
under Conference Action level funding
(Non-add)

Mothers receiving prenatal and post-natal care	555,000
Infants admitted for comprehensive services	153,550
Children registered for comprehensive services	1,669,625
Women receiving nursing services	1,820,400
Children receiving nursing services	2,833,275
Children receiving dental treatment	910,200

Estimated Numbers of People Served in 1976
under Conference Action level funding (cont'd)
(Non-add)

Children screened:	
Visual screening	9,107,550
Audiometer testing	6,071,700
Dental screening	3,035,850
Children immunized (Including boosters and revaccinations):	
Polio	2,782,400
Rubella	3,035,850
Diphtheria	3,035,850
Crippled children receiving physician services	508,750

Twenty-four service demonstration projects were funded in 1976. The objectives of these projects are to 1) provide counseling services for families which lose a child due to sudden infant death syndrome, 2) increase the awareness of the public in general and community service personnel in particular, and 3) develop and strengthen linkages between community agencies such as health agencies, mental health agencies and coroner or medical examiners' offices, police and fire departments. In addition, a variety of publications and audio-visual materials were produced and disseminated.

In 1976 research activities supported 93 projects, addressing such areas as child abuse, adolescent pregnancy, improving utilization of health personnel, sudden infant death, evaluation of delivery programs, perinatal care, nutrition of mothers and children, and predicative tests for parenting capabilities.

-- From 1967 to 1976 the cumulative number of persons trained under the University-Affiliated Mental Retardation Centers program was 2,966.

-- The cumulative number of persons trained through 1976 under the Physicians Assistants and Nurse Practitioners Programs, started in 1972, was 609.

The following summarizes the number of trainees supported in 1976 under both programs:

-- Supported training for 551 trainees:

1. University-Affiliated Mental Retardation Centers (21 Centers)

Long-term Trainees:

Physicians	54
Nutritionists	8
Pedodontists	24
Medical Social Workers	115
Psychologists	83
Speech Therapists	70
Physical Therapists	18
Others	40
Subtotal	412

2. Physicians Assistants and Nurse Practitioner Programs

Long-term Trainees:

Pediatric Nurse Practitioners	85
Nurse Midwives	30
Other Physicians Assistants	24
Subtotal	139
Total	551

-- The pediatric pulmonary Center program trained 109 persons in 1976.

Objectives in 1977: States will continue to provide health and related services to mothers, children and crippled children. Efforts will be directed to maximizing the utilization of funds to insure that the greatest number of persons receive services within the reduced availability of resources.

-- Programs of projects will be reduced from 280 to 205.

The Sudden Infant Death Syndrome program is proposed for termination in 1977.

Sixteen university-affiliated training centers will be supported in 1977 providing training to approximately 330 health professionals. The pediatric nurse practitioner and other physician assistants programs will train approximately 100 persons. The research activity will be continued through 74 projects directed toward improving the effectiveness and quality of services for mothers, children and crippled children.

Training Activities:

1. University-Affiliated Mental Retardation Centers (16)

Long-term Trainees:

Physicians	43
Nutritionists	6
Pedodontists	24
Medical Social Workers	94
Psychologists	60
Speech Therapists	56
Physical Therapists	14
Others	33
Subtotal	330

2. Physician Assistants and Nurse Practitioner Programs

Long-term Trainees:

Pediatric Nurse Practitioners	65
Nurse Midwives	24
Other Physicians Assistants	11
Subtotal	100
Total	430

-- The pediatric pulmonary center training program will be phased out in 1977.

-- Funds in this request will be included in the proposed block grant for health.

Program Purpose and Accomplishments

Activity: Community health services -- Family planning project grants and contracts (PHS Act, Title X)

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$100,615,000	$182,500,000	---	$79,435,000

Purpose: The goal of the family planning service program is to provide a full range of high quality family planning services to people who want such services but for financial or other reasons do not have access to them.

Explanation: Project grants are made under Title X of the PHS Act to State and local health departments and other public or nonprofit organizations to provide family planning services. Title X authorizes project grants and contracts for the training of family planning workers, studies of new and improved methods of delivering family planning services, and the development and distribution of family planning educational materials.

Accomplishments in 1976: The program will provide family planning services to 2,200,000 patients in 1976. Efforts to improve program efficiency and productivity and to upgrade the quality of services provided will continue. Cost reporting requirements will be implemented which will assure that funding decisions are made on a uniform cost basis. Ambulatory health care surveys and medical audits will be completed in a sample of service sites. A technical assistance program will be conducted to assist projects in implementing these initiatives.

The emphasis in training will be to improve skills of staff delivering medical services. Priority will be given to increasing the number of nurse practitioners trained by 20. Information and education activities will be directed primarily to the high risk and hard-to-reach populations, and will include a model program for delivering educational services to the mentally retarded. Special studies of informed consent education and the impact on patients' choice of methods will be initiated.

The services delivery improvement strategy will continue to stress the development and implementation of more effective methods of delivering services and managing family planning programs. The Region I data system which was expanded to incorporate an automated billing system to assist in collecting third party reimbursements will be tested and implemented in other areas. Projects will receive technical assistance in implementing study and demonstration findings.

Objectives for 1977: The program will continue to provide comprehensive family planning services to approximately 1,748,000 people. Emphasis will be on providing quality services in the most cost effective manner. Addressing the maldistribution of health manpower and identifying strategies to insure that service deliverers in rural areas have the skills necessary to enable them to effectively deliver services will be priorities of the training program. An assessment of family planning manpower development and utilization will be conducted, and informed consent educational materials for teenagers and a minimum patient education program will be developed. Nutrition counselling as a component of educational services will be studied. Funds in this request will be included in the proposed block grant for health.

Activity: Community health services -- Migrant health (PHS, Section 319, as amended)

1976 Appropriation		1977 Authorization	1977 Budget Estimate	
Pos.	Amount		Pos.	Amount
---	$25,000,000	$44,000,000	---	$19,200,000

Purpose: This program provides access to health care services for migrant and seasonal farmworkers and their families.

Explanation: Under Section 319 of the Public Health Service Act as amended support is provided to establish family health clinics and to improve the health care and health conditions of agricultural migrant workers and their families.

Accomplishments in 1976:

-- Implemented the National referral system and increased the number of projects in the system from 15 to 105.
-- Developed 7 Centers.
-- Conducted a migrant labor housing study.
-- Implemented 3 program assistance contracts to improve the sanitation in the migrant's living and working environment.
-- Provided services to 399,000 migrants and encounters to 655,000 migrants.
-- Provided hospitalization services to 1,875 persons.
-- Provided project staff training to 60 persons in the sanitation program.

Objectives for 1977: The program will continue to provide health care services to 353,000 people. No Centers will become operational in 1977. States programs assistance contracts for improvement of sanitation in migrant labor camps will be discontinued. Funds in this request will be included in the proposed block grant for health.

Activity: Community health services - Health maintenance organizations (PHS Act, Section 301 and Title XIII)

	1976 Appropriation		1977 Authorization	1977 Budget Estimate	
	Pos.	Amount		Pos.	Amount
Budget Authority	129	$18,612,000	1/	129	$18,612,000
Obligations.....	129	19,339,000		129	18,612,000

Purpose: The Health Maintenance Organization Act of 1973 (P.L. 93-222) provides authority for a five-year program of assistance to promote the development of new and expansion of existing health maintenance organizations (HMOs). The legislation is based on the concept that assistance to HMOs is one of the more effective means of dealing with specific major problems on health care today, such as:

-- the rapid inflation in medical care
-- the inadequate emphasis on illness prevention
-- an increasing uneveness in the distribution and quality of medical care.

1/ Financial assistance grants and contracts (1309(a)), $85,000,000; direct loans (1309(b)), $75,000,000 in the aggregate for 1974 and 1975; loan guarantees (1308(d)), indefinite; program support (301), indefinite. The initial authorization limits funding of grants and contracts to initial development projects only in 1977; however, based on testimony of the Assistant Secretary for Health on November 21, 1975 in support of a one-year extension of the HMO grant activity, planning grants are also funded in 1977.

HMOs provide comprehensive health services on a prepaid capitation basis in accord with the definitions contained in the HMO Act.

Explanation: Grants and contracts for feasibility studies, planning and initial development are provided to public and private non-profit entities through financial assistance from the Health Maintenance Organization (P.L. 93-222). Priority for all types of assistance will be given to HMOs which will serve medically underserved populations; 20% of the funds are set aside for rural HMOs.

The revolving loan and loan guarantee fund was capitalized with $35,000,000. Loans are sold to the Federal Financing Bank thereby replenishing this fund, hence no additional funds are requested. Loans are made from this fund to help cover operating deficits during the first three years of an HMO's operation.

Accomplishments in 1976: The 1976 grant activity included the funding of 32 feasibility studies at an average cost of $50,000 each, 21 planning projects at approximately $125,000 each and 15 initial development activities at an average cost of $767,000 each.

During 1976, 25 loans totalling $37,500,000 will be placed with a potential of providing services to approximately 750,000 enrollees at the maturity of the HMOs.

Objectives for 1977: There will be no feasibility starts in this period; however, 24 planning projects at a cost of approximately $3,000,000 and 15 initial development projects costing $12,000,000 plus 14 loans for initial operations at an investment of $21,000,000 will be initiated. These will provide the nucleus for approximately 50 HMOs with a potential for eventually serving 1,500,000 enrollees.

The Office of Health Maintenance Organization Qualification and Compliance will promote the program for qualifying entities seeking recognition as qualified health maintenance organizations, administer the mandatory offering of the health maintenance organization alternative in Employees Benefits Plans (dual choice), and maintain surveillance to assure continuous compliance by qualified health maintenance organizations to the requirements of the statute and regulations. This Office deals with the total universe of health maintenance organizations and it is anticipated that in addition to the 50 applications for qualifications received during 1976, 100 additional applications will be processed in 1977.

A program support level of $3,612,000 will support 129 employees who will continue to review and monitor grants; render technical assistance to emerging HMOs and continue to support and aid all entities having received grants under P.L. 93-222.

Activity: Community health services -- National Health Service Corps (PHS Act, Section 329, as amended).

	1976 Appropriation		1977		
				Budget Estimate	
	Pos.	Amount	Authorization	Pos.	Amount
Budget Auth...	701	$15,000,000	*	676	$24,529,000
Obligations...	701	$20,000,000		676	$24,529,000

* Authorization expires at the end of Fiscal Year 1976.

Purpose: The purpose of the National Health Service Corps (NHSC) is to help alleviate the geographic maldistribution of health manpower by providing health professionals to communities where shortages exist.

Explanation: This activity is responsible for the recruiting and assigning of appropriate health personnel to critical health manpower shortage areas; assisting communities in developing the capacity to plan, build, and maintain

their own systems of health care: and concurrently pursuing policies that will encourage health professionals, once placed, to remain in shortage areas on a non-Federal basis.

Accomplishments in 1976: In 1976, there were 551 health professionals (342 physicians, 104 dentists, and 105 nurse practitioners and allied health personnel) assigned to 270 communities in 44 States and Guam and Puerto Rico. Conference Action provided for addition of 150 medical personnel serving 182,000 people in 70 communities.

During 1976, the National Health Service Corps utilized information gained through review and evaluation of site activities and developed and put into effect, or made available, procedures useful to communities and health professionals in site operations, such as patient and practice management systems and the problem-oriented medical records system.

Evaluation of location decisions by physicians resulted in improved matching procedures, increased emphasis on recruitment of board eligible physicians (from 45% - 65% in 1976), expanded continuing medical education services such as providing audio-visual capabilities to all medical sites, and increased emphasis on establishment of group rather than solo practice sites.

During 1976, the NHSC actively participated in the Rural Health Initiative (RHI), providing up to 200 personnel for about 70 RHI sites. Integration of NHSC staff with other programs will improve the overall Federal health delivery capacity and efficiency. It will also maximize the self-sufficiency potential of the local health care delivery systems and will create a professional environment very conducive to physician retention. In 1976, the number of independent sites increased from 60 to about 94, and the retention rate increased from 26% to about 35%.

Objectives for 1977: This request will support 676 health professionals in 330 communities.

Program activities will be continued and refined to monitor and assist sites in attaining financial and operational self-sufficiency and independence. About 56 new sites will be identified and developed to replace those becoming independent in 1977. Sixty additional sites will be developed to bring the level to 330 staffed sites. About 150 areas will be newly designated as critical health manpower shortage areas bringing the total to 1,550; about 100 designated areas will be newly approved as eligible for NHSC assistance, totalling 650.

The number of board eligible physicians is expected to increase from 65% in 1976 to 70% in 1977. The number of multiple provider sites will be significantly increased in 1977. The retention rate is expected to increase from 35% in 1976 to 40% in 1977.

The utilization of waiver authority and equipment transfer as mechanisms to aid communities in attaining economic independence, although authorized in 1976, will be assessed and refined in 1977.

During 1977, there will be increased emphasis on providing comprehensive health services at sites. While the number of dental sites was increased from 55 to about 100 in 1976, procedures will be developed and implemented in 1977 to integrate the dental and medical services provided to communities.

The NHSC will continue active participation in the Rural Health Initiative. Also, problems of access to medical care in urban areas will be newly examined to determine desirability, extent, and possible mechanisms for provision of assistance.

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Activity: Community health services -- Grants to States under Section 314(d)(7)(B) PHS Act for Hypertension Program

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$3,750,000	$15,000,000	---	---

Purpose: These formula grants are awarded to State health authorities to assist in meeting the costs of establishing and maintaining programs for the screening, detection, diagnosis, prevention, and referral for treatment of hypertension.

Explanation: Under Section 314(d)(7)(B) of the PHS Act, grant funds will be allocated to State health authorities on the basis of (1) one dollar per person up to the first 10,000 population and (2) on a State's population and financial need weighted by the extent of the hypertension problem within the State.

Accomplishments in 1976: Funds appropriated will be made available to State health authorities for establishing and maintaining hypertension programs.

Objectives for 1977: No funds are requested for grants to State health authorities for support of hypertension programs. Instead, a block grant totalling $10 billion will be awarded to States to fund, at the discretion of the States, activities such as those supported under the Comprehensive Public Health Grants to States program.

Activity: Community health services - Home health services (Title VI, PHS Act as amended)

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$3,000,000	1/	---	---

Purpose: The purpose of this program is to demonstrate the establishment and initial operation of public and non-profit private agencies which will provide home health services in areas in which such services are not otherwise available.

Explanation: Title VI provides for the making of project grants to improve the delivery of home health services. The intent is to provide initial funding with a view to the projects which are funded becoming independent of federal support.

Accomplishments in 1976: Funds for support of this program were included in the 1976 supplemental budget request and were planned for use in establishing 20 new home health agencies and providing supplemental funding to an additional 20 already existing agencies. The funds requested were subsequently proposed for rescission.

Objectives in 1977: Authorization for this program expires in 1976.

1/ This program was authorized for 1976 only at a level of $10,000,000

Activity: Community health services - Hemophilia programs (Sections 1131 and 1132, Title VI, PHS Act as amended)

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$3,000,000	$9,000,000 1/	---	---

Purpose: Title VI of P.L. 94-63 authorizes the support of hemophilia treatment centers which will provide treatment to sufferers in their areas, develop associations with providers distant from the centers and develop training programs in hemophilia research, diagnosis and treatment. In addition, the Act authorizes support for projects to develop and expand existing capability to separate and make blood components available to blood service providers and fraction manufacturers. If fractions are found to be in short supply, grants may also be made to existing public or non-profit manufacturers to alleviate the shortage.

Explanation: Project grants and contracts are awarded to public and non-profit entities to establish comprehensive hemophilia treatment centers and to develop and expand, within existing facilities, blood separation centers.

Accomplishments in 1976: Grants and contracts were planned for award in 1976 and funds were included for this purpose in the supplemental budget request. These funds were subsequently proposed for rescission.

Objectives in 1977: No funds are requested for these activities in 1977.

1/ $4,000,000 for Hemophilia Treatment Centers
$5,000,000 for Blood Separation Centers

Activity: Quality assurance - Medical care standards (PHS Act, Sections 301 and 311)

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
170	$5,187,000	Indefinite	170	$4,187,000

Purpose: The Bureau of Quality Assurance provides the professional health expertise necessary for implementing the Department's responsibilities, through standard setting and enforcement, for assuring the health and safety of Medicare and Medicaid beneficiaries, through the appropriateness and quality of services provided to such beneficiaries.

Explanation: This activity provides for the development of specialized programs related to medical care administration, including the professional health aspects of Title XVIII of the Social Security Act. The Bureau accomplishes it objective by participating with the Bureau of Health Insurance (SSA) and the Medical Services Administration (SRS) in the development, interpretation and evaluation of program regulations, policies and procedures, and in the field administration of such program requirements.

Accomplishments in 1976: In 1976, 850 provider validation surveys will have been conducted, an increase of 200 over 1975. A total of 8,260 proficiency examinations will have been administered to physical therapists, licensed practical nurses, cytotechnologists, clinical laboratory technologists and psychiatric technicians, an increase of about 1,000. In addition, final ESRD regulations will have been published and policies, procedures, and guidelines for implementation

will have been developed. Surveyors of ESRD facilities will have been trained to carry out certifications and provide consultation directed towards improving services. A total of 1,700 surveyor personnel will have been trained, an increase of about 200. Phase I of the ESRD Medical Information System will have been completed and the system readied for implementation of Phase II. Planning for the establishment of Medical Review Boards will have been initiated.

Objectives for 1977: The estimate would allow for about 850 provider validation surveys, the same as 1976. Surveyor training activities for about 450 State survey personnel would be supported. Implementation of Phase II of the ESRD Medical Information System (system implementation) will be curtailed. Planning for the establishment of Medical Review Boards will continue. Health and safety standards for existing and new providers will continue to be updated and new standards that emphasize patient outcomes will be developed.

Activity: Quality Assurance--Professional Standards Review Organizations (Social Security Act as amended, Title XI, Part B)

	1976 Appropriation		1977 Budget Estimate		
	Pos.	Amount	Authorization	Pos.	Amount
Budget Authority..	---	$26,455,000	Indefinite	---	$27,066,000
Obligations.....	173	47,582,000	---	221	62,000,000

Purpose: To assure, through the application of suitable procedures of professional standards review, that the services financed by Titles XVIII, XIX, and V of the Social Security Act will conform to appropriate professional standards for the provision of health care. To promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made.

Explanation: The PSRO program was authorized by the 1972 amendments to the Social Security Act. This provision of Public Law 92-603 (Section 249F) requires the Secretary to establish and support a nationwide network of voluntary, nonprofit groups of local physicians to regulate the quality and costs of health care services financed by and provided to beneficiaries and recipients of Medicare, Medicaid, and Maternal and Child Health programs. PSRO's objectives are to accomplish this by applying sophisticated concepts of peer review through a system of voluntary local organizations, Statewide Councils, and a National Council supported, regulated, monitored, and evaluated by the Federal Government.

Accomplishments in 1976: In 1976, two planning PSROs will have been converted to conditional status for a total of 65 conditional PSROs. Fifty-five PSROs will remain in planning status, and six Statewide Councils will have been established. The 65 conditionals will have performed review of about 1.9 million Medicare/Medicaid hospital admissions.

Objectives for 1977: Early in 1977 the PSRO program will convert 55 planning PSROs to conditional status for a total of 120 conditional PSROs. The capability of these conditionals to conduct review of about 65-75% of the hospital admissions will be made possible through implementation of the new financing amendments. Eighty-three new planning PSROs will be funded. PSROs will be established in all 203 PSRO areas. Review will be performed on approximately 3.0 million Medicare/Medicaid hospital admissions. In addition a total of 10 Statewide Councils will be established.

Activity: Patient care and special health services -- Patient care (PHS Act, Titles I, II, V, XI and XIII)

1976 Appropriation		1977	1977 Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
5,479	$116,164,000	Indefinite	4,913	$105,164,000
Obligations				
5,479	136,056,000		4,913	125,056,000

Purpose: The primary purpose of this program is to provide for the comprehensive health care of American seamen, Coast Guard, National Oceanographic and Atmospheric Administration, and PHS Commissioned Corps personnel, and persons with Hansen's disease. On a reimbursable basis, health care is also provided in PHS hospitals and outpatient clinics to beneficiaries of other Federal agencies, foreign seamen, and community programs.

Explanation: To carry out this mission, funds have been appropriated to operate Public Health Service hospitals and clinics and, where necessary, to provide for care of primary beneficiaries through contractual arrangements with other Federal and non-Federal hospitals, and with private physicians and dentists. Medical care is also provided on a reimbursable basis to beneficiaries of other Federal agencies, foreign seamen, and community programs.

Accomplishments in 1976: Health care was made available to an estimated 500,000 PHS beneficiaries, in addition to beneficiaries of other Federal agencies, foreign seamen, and community programs. There was a daily average of 1,638 inpatients and 6,236 outpatient visits to PHS facilities. Contract care in other Federal and non-Federal facilities averaged 83 inpatients per day; in addition, there will have been 76,000 outpatient visits to private physicians and dentists.

Objectives for 1977: Legislation will be submitted to Congress to authorize closure or transfer to community use of the eight Public Health Service general hospitals. The Public Health Service will continue to operate the National Leprosarium at Carville, Louisiana, and the PHS outpatient clinics. With the closure of the PHS hospitals, medical care will continue to be provided to primary beneficiaries on a contract basis. Plans will be formulated for the administration of a contract medical care program for beneficiaries and for the disposition of the Federally-owned PHS hospitals.

Closure or transfer to community use of the eight PHS hospitals is sought for the following reasons:

- Current use of the facilities is very low--an estimated 69% of capacity for 1976.
- Only 53% of the patients using the hospitals are primary beneficiaries.
- The hospitals are located in areas where adequate community facilities are available to take care of current PHS patients if the PHS hospitals were closed. This would not adversely affect the availability of adequate hospital resources to the community.
- Five of the eight PHS hospitals (Galveston, Seattle, Baltimore, Boston, and San Francisco) are in areas with an excess of hospital beds for community needs. Continued operation of the PHS facilities in such areas tends to push up community hospital costs.

Activity: Patient care and special health services -- Federal employee health services (P.L. 79-658, August 8, 1946 (5 USC 7901)

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
267	$606,000	Indefinite	267	$606,000
Obligations				
267	6,830,000		267	7,007,000

Purpose: Appropriated funds are used to provide consultation services and to make surveys of existing health services, when requested by Federal agencies, on the conduct of Federal employee occupational health programs. This program also operates health units providing occupational health services to Federal agencies on a reimbursable basis.

Explanation: Prior to establishing a Federal employee health program, all Federal agencies must, by law, consult with the Public Health Service regarding program standards. The appropriated funds provide for consultation services to any Federal agency, on request, on the establishment or evaluation of Federal employee occupational health programs. Within its capabilities, the Public Health Service also provides, under reimbursable authority, and upon request, employee health services to Federal agencies.

Accomplishments in 1976: In 1976, 100 consultations to Federal agencies, executive boards, and associations were provided on the evaluation and establishment of Federal employee health activities. Occupational health services were provided to approximately 200,000 Federal employees in 106 health units.

Objectives for 1977: The estimate for 1977 provides for continuation of employee health activities at the 1976 level. The program will continue to be responsive to Federal agencies for requested consultation and evaluation of their occupational health programs and will continue to operate 106 health units providing services to approximately 200,000 Federal employees.

Activity: Patient care and special health services -- Payment to Hawaii (PHS Act, Section 331)

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$1,200,000	Indefinite	---	$1,200,000

Purpose: Payments are made to the State of Hawaii for care and treatment of persons with Hansen's disease.

Explanation: The appropriated funds are paid as a reimbursement of actual expense to the Department of Health of Hawaii to assist in care and treatment of Hansen's disease in its facilities. Any expenses above the appropriated funds are borne by the State of Hawaii.

Accomplishments in 1976: Care will be provided to an estimated daily average of 134 inpatients. This is a continuation of the decreasing inpatient load of recent years. Of the total program costs estimated to be $2,081,000, the share borne by Hawaii is $881,000.

Objectives for 1977: The average daily patient load is expected to be 131 in 1977. The total program requirements are estimated to be $2,132,500 of which the Federal Government will pay $1,200,000. Funds in this request will be included in the proposed block grant for health.

Activity: Emergency Medical Services (PHS Act, Title XII)

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$37,025,000	1/	---	$25,100,000

Purpose: The Emergency Medical Services Systems program was established in 1973 to support the implementation of self-supporting regional emergency medical services systems, which have direct impact on the loss of life due to accidental injury and sudden illness. These EMS systems should be accessible to virtually all of the Nation's citizens.

Explanation: Grants and contracts provide financial assistance for (1) the conduct of feasibility studies and planning, (2) establishing and initial operation, (3) expansion and improvement, and (4) research projects for the development of area emergency medical services systems. Priority for funding is given to rural and other underserved areas.

Accomplishments in 1976: During 1976, an estimated 75 planning studies will be undertaken, 47 regional systems will have had financing completed toward establishing and operating basic life support emergency medical services systems, and 43 regions will be in the process of expanding and improving existing advanced life support emergency medical services systems.

Objectives for 1977: The budget estimate will provide financing for four regions to initiate a program for the establishment and initial operation of an EMS system, and 93 regions will have received financing to expand and improve their existing advanced life support systems. On a cumulative basis, 124 self-supporting regional emergency medical services systems will be in some phase of operational development, serving a population of approximately 62,000,000. The following table indicates the estimated number of emergency medical services systems and available financing for the various sections of the Emergency Medical Services Systems Act. Funds in this request will be included in the proposed block grant for health.

1/ Legislative authority for the program expires June 30, 1976. New legislation has been proposed.

	1976	1977
Feasibility and planning:		
No. of systems funded	75	--
Amount of available financing	$3,400,000	--
Initial operations:		
No. of systems funded	47	4
Amount of available financing	$18,800,000	$1,700,000
Expansion and improvement:		
No. of systems funded	43	93
Amount of available financing	$10,900,000	$23,400,000
Sub-total:		
No. of systems funded	165	97
Amount of available financing	$33,100,000	$25,100,000
Research:		
No. of grants awarded	25	--
Amount of available financing	$3,925,000	--
Total amounts of available financing	$37,025,000	$25,100,000

Activity: Buildings and facilities

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
Budget Authority				
---	---	Indefinite	---	---
Obligations				
---	$13,815,000		---	---

Purpose: For construction, alterations, repairs and improvements of buildings and facilities, including preparation of plans and specifications.

Explanation: Funds appropriated are available until used for the purpose of this activity.

Accomplishments in 1976: Obligations are directed toward upgrading the PHS hospitals. In 1976, approximately $14 million from prior year balances will be obligated to support repair and improvement projects, i.e., 31 projects for fire and safety code deficiencies, 33 projects for urgent facility repairs and renovation, 13 projects to meet the Joint Commission on Hospital Accreditation requirements, and 25 projects for program improvements.

Objectives for 1977: The budget policy is to propose new legislation to transfer to community use or to close the Public Health Service hospitals, excluding outpatient clinics and the National Leprosarium at Carville, Louisiana. Under this policy, budget authority for construction activities is not requested in 1977.

Activity: Program management--Bureau of community health services (PHS Act, Section 301)

1976 Appropriation		1977 Authorization	1977 Budget Estimate	
Pos.	Amount		Pos.	Amount
641	$18,929,000	Indefinite		$18,826,000

Purpose: This activity provides for the overall planning, direction, and administration for the programs of the Bureau of Community Health Services (BCHS).

Explanation: This is a direct operating program which includes salaries and other operating funds to provide management support for the Bureau of Community Health Services. The positions supported in this activity are utilized in headquarters to provide national leadership and direction to legislatively mandated programs, and in regional offices to provide grant administration and a full range of technical assistance and program guidance to present and potential communities and recipients of grants, contracts and loans.

Accomplishments in 1976: In 1976, efforts were directed toward expansion of community health centers' delivery capability through increased productivity, improvement of the quality and scope of services offered, and the development and improvement of the management structure.

Maternal and child health program objectives for 1976 were met, including the development of cost and utilization reporting requirements, implementation of a program for assisting States in analyzing maternal and child health needs for services, provision of technical assistance to 56 political jurisdictions, development of specific criteria for evaluating the Program of Projects, development of policies for coordinating the activities of State Title V programs and local Professional Standard Review Organizations.

The family planning program accomplishments included the development of a new reporting system and cost reporting requirements, self-instructional materials for patients, a service-integration initiative whereby family planning services were integrated with other BCHS programs, and medical care guidelines and mechanisms for improving project performance.

The migrant health activities in 1976 were directed to the continued development of health services for migrant and seasonal farmworkers, implementation of a program to improve environmental sanitation, and a national record retrieval and referral system.

National health service corps staff continued to recruit and match health professionals. Approximately 551 such professionals were active in 270 sites in 1976. Essential operational technical assistance was provided to both on-going and newly-staffed sites.

Objectives for 1977: The Bureau of Community Health Services staff will be placing primary emphasis on maximizing the use of the reduced resources proposed for the project grants for fiscal year 1977. This is necessary to maintain existing health care services to maximum extent possible. This effort is particularly significant for the people currently being served by community health centers, family planning projects, and migrant health projects.

Major efforts will also continue in relation to the following activities: Technical assistance will be provided to States with regard to implementation of maternal and child health activities, including improved project management and increased third-party reimbursements; the designation of critical health manpower shortage areas and the assignment of national health service corps health professionals to the extent provided by the 1977 budgeted level for the activity; the provision of pre-operational and post-operational technical assistance to approved and matched national health service corps sites; coordination of those programs participating in the rural health initiative; implementation of program indicators and reporting requirements in relation to community health centers, migrant health, and family planning projects.

Activity: Program management - Bureau of Medical Services
(PHS Act, Section 301)

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
123	$3,509,000	Indefinite	123	$3,494,000

Purpose: This activity provides for the overall planning, direction, and administration of the Bureau of Medical Services' program--Patient Care, Federal Employee Health, Payment to Hawaii, Buildings and Facilities, and Emergency Medical Services.

Explanation: Program direction and management services are provided for all of the Bureau's programs. The positions supported in this activity are utilized in Headquarters to provide national leadership and direction to legislatively mandated programs, and in Regional Offices to provide grant administration and a full range of technical assistance and program guidance to present and potential communities and recipients of grants and contracts.

Accomplishments in 1976: Program guidance and services were provided to: (1) more effectively administer the program for delivering health care services to Public Health Service beneficiaries; (2) further implement and improve occupational health programs for Federal employees; and (3) continue the initial progress being made in bringing more and better emergency medical care systems to the Nation.

Objectives for 1977: With the plan to propose legislation to authorize the transfer to community use or the closure of the eight PHS general hospitals, special emphasis will be placed on administering a contract care program to provide hospital services for PHS beneficiaries after closure of the PHS hospitals. Plans will also be developed and implemented for the orderly disposition of the Federally-owned PHS hospitals, upon closure.

Program management and services will continue to be provided the Carville Leprosarium and PHS outpatient clinics, the Federal Employee Health program, and the Emergency Medical Services activity.

Activity: Program Management - Office of the Administrator
(PHS Act, Section 301)

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
177	$3,970,000	Indefinite	177	$3,963,000

Purpose: This activity provides for the overall planning, direction, and administration of the Health Services Administration programs.

Explanation: This is a direct operating program which includes salaries and related costs to provide management support for the Health Services Administration's programs.

Accomplishments in 1976: The Office of the Administrator provides policy guidance and evaluation of Agency progress in achieving its objectives to all programs with concentration on overseeing major new program initiatives. These includes Health Maintenance Organizations, Professional Standards Review Organizations, Emergency Medical Services Systems, and emphasis on improving project grant management and increasing third-party reimbursements. Programs for Hypertension, Home Health and Hemophalia were also initiated.

Objectives for 1977: The Office of the Administrator will plan, give direction and provide administrative support for a broad scope of programs and activities in the Health Services Administration. The Office of the Administrator will continue to formulate policies, regulations, program plans, and evaluate Agency programs in mission accomplishment. The Office of the Administrator will continue to structure, implement and oversee new program initiatives within the agency, such as: Health Maintenance Organizations, Emergency Medical Service Systems, Professional Standards Review Organizations, improved project grant management, and third-party requirements.

Activity: Program Management - Payment to GSA

1976 Appropriation		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$4,255,000	Indefinite	---	$3,380,000

Purpose: This activity provides rental payments to GSA for programs funded from the Health Services appropriation.

Explanation: This activity provides direct payment to GSA.

Accomplishments in 1976: Funds were provided to support the rental payments to GSA.

Objectives for 1977: Payment to the General Services Administration for rent will continue to be provided. However, rent is included for the Public Health Service hospitals and clinics for only a portion of fiscal year 1977.

Allocations of Grants to States for Comprehensive Health Services[1/]

States	1975 Actual	1976 Appropriation	1977 Request
Alabama	$1,655,300	$1,658,900	---
Alaska	402,400	402,800	---
American Samoa	265,700	257,900	---
Arizona	1,001,200	1,038,200	---
Arkansas	1,086,900	1,074,200	---
California	6,813,200	6,926,100	---
Colorado	1,102,200	1,126,800	---
Connecticut	1,243,400	1,246,200	---
Delaware	478,300	477,400	---
District of Columbia	513,100	514,900	---
Florida	2,882,900	3,009,300	---
Georgia	2,005,500	2,032,000	---
Guam	319,800	301,000	---
Hawaii	561,500	567,500	---
Idaho	578,800	582,400	---
Illinois	3,803,500	3,756,700	---
Indiana	2,091,100	2,073,400	---
Iowa	1,285,500	1,224,300	---
Kansas	1,059,800	1,032,800	---
Kentucky	1,542,500	1,546,800	---
Louisiana	1,713,600	1,717,900	---
Maine	681,800	686,000	---
Maryland	1,599,200	1,600,700	---
Massachusetts	2,162,200	2,181,800	---
Michigan	3,188,200	3,176,100	---
Minnesota	1,622,900	1,584,500	---
Mississippi	1,217,100	1,226,200	---
Missouri	1,915,900	1,913,000	---
Montana	553,600	552,000	---
Nebraska	819,700	799,500	---
Nevada	471,300	477,800	---
New Hampshire	569,900	576,700	---
New Jersey	2,576,700	2,562,800	---
New Mexico	713,700	727,000	---
New York	5,945,100	5,953,400	---

1/ Allocations are awarded to States based on population and per capita income with a minimum program requirement.

Allocations of Grants to States for Comprehensive Health Services[1/]

States	1975 Actual	1976 Appropriation	1977 Request
North Carolina	$2,207,600	$2,229,100	---
North Dakota	533,100	498,600	---
Ohio	3,849,200	3,842,100	---
Oklahoma	1,263,600	1,267,300	---
Oregon	1,056,100	1,065,500	---
Pennsylvania	4,266,000	4,236,200	---
Puerto Rico	2,160,700	2,003,500	---
Rhode Island	623,100	616,000	---
South Carolina	1,334,300	1,355,900	---
South Dakota	550,500	533,000	---
Tennessee	1,820,100	1,821,100	---
Texas	4,458,500	4,489,500	---
Trust Territory	454,800	452,600	---
Utah	722,400	733,000	---
Vermont	470,100	473,600	---
Virgin Islands	265,700	259,800	---
Virginia	1,933,300	1,949,500	---
Washington	1,441,400	1,438,000	---
West Virginia	968,300	971,600	---
Wisconsin	1,859,000	1,856,500	---
Wyoming	418,900	422,600	---
Total	89,100,000	89,100,000	---
Evaluation Amount[2/]	900,000	900,000	---
Grand Total	90,000,000	90,000,000	---

1/ Allocations are awarded to States based on population and per capita income with a minimum program requirement.

2/ Authorized by P.L. 91-296.

Allocations of Grants for Maternal and Child Health Services

Actual and Estimated Awards[1/]
Fiscal Years 1975-7

States	1975 [2/] Actual	1976 Appropriation	1977 Request
Alabama	$4,159,000	$4,509,600	$3,456,600
Alaska	368,000	444,000	324,000
American Samoa	100,000	166,400	163,500
Arizona	1,372,000	1,692,800	1,475,700
Arkansas	2,281,000	2,534,700	2,057,900
California	10,313,000	10,171,100	7,919,700
Colorado	1,658,000	1,668,500	1,422,800
Connecticut	1,454,000	1,402,600	1,055,700
Delaware	578,000	583,400	445,700
District of Columbia	478,000	497,000	374,900
Florida	5,273,000	5,588,200	4,572,500
Georgia	5,424,000	6,159,700	4,911,400
Guam	264,000	306,600	288,800
Hawaii	687,000	554,400	480,300
Idaho	788,000	922,700	823,500
Illinois	5,817,000	6,050,400	4,752,500
Indiana	4,417,000	4,766,700	3,761,500
Iowa	2,436,000	2,511,900	1,913,600
Kansas	1,591,000	1,604,100	1,254,200
Kentucky	3,893,000	4,493,000	3,499,100
Louisiana	4,396,000	4,687,500	3,676,400
Maine	1,139,000	1,310,200	1,006,000
Maryland	3,606,000	3,626,800	2,713,300
Massachusetts	2,935,000	3,093,600	2,348,200
Michigan	6,692,000	6,666,600	5,217,800
Minnesota	3,112,000	3,137,700	2,453,000
Mississippi	3,475,000	3,789,000	2,951,800
Missouri	3,827,000	4,146,700	3,408,500
Montana	696,000	810,500	663,000
Nebraska	1,171,000	1,269,500	1,029,400
Nevada	372,000	383,400	326,300
New Hampshire	666,000	801,700	629,700
New Jersey	3,645,000	3,303,000	2,631,900
New Mexico	1,123,000	1,292,500	1,067,600
New York	8,712,000	9,747,400	7,427,900
North Carolina	6,110,000	6,885,500	5,467,200
North Dakota	668,000	611,200	493,200
Ohio	7,749,000	8,581,600	6,543,100
Oklahoma	2,064,000	2,389,000	1,913,900
Oregon	1,893,000	1,934,900	1,587,800

Allocations of Grants for Maternal and Child Health Services (Cont'd)

Actual and Estimated Awards[1/]
Fiscal Years 1975-7

States	1975 [2/] Actual	1976 Appropriation	1977 Request
Pennsylvania	$8,464,000	$9,275,300	$7,059,500
Puerto Rico	4,592,000	5,635,800	5,105,500
Rhode Island	547,000	515,800	407,400
South Carolina	3,781,000	4,309,700	3,425,600
South Dakota	734,000	793,700	639,500
Tennessee	4,015,000	4,413,300	3,440,400
Texas	8,741,000	9,790,200	7,642,700
Trust Territory	342,000	448,400	435,900
Utah	1,424,000	1,580,900	1,482,000
Vermont	561,000	658,100	497,400
Virgin Islands	248,000	230,000	191,800
Virginia	4,318,000	4,647,000	3,579,800
Washington	2,919,000	2,953,900	2,286,400
West Virginia	2,008,000	2,393,000	1,909,800
Wisconsin	3,496,000	3,754,500	2,914,600
Wyoming	330,000	377,000	319,300
Total distribution by formula[1/]	163,922,000	176,872,500	139,847,500
Special projects for mentally retarded children	4,708,000	4,750,000	3,420,000
Other special projects	7,973,000	8,937,217 [3/]	3,926,500
Total	176,603,000	190,559,717	147,154,000

1/ (a) One-half of the amount appropriated for each year is apportioned among States on the basis of a uniform grant of $70,000 and an additional grant in proportion to the number of live births in the State. Amounts awarded must be matched dollar for dollar.

(b) The remaining half, after being reduced by the amounts reserved for the two categories of special projects, is apportioned by formula. Each State receives an amount which varies directly with the number of urban and rural births in the State and inversely with State per capita income. No State receives less than $70,000 and rural live births are given twice the weight of urban births.

(c) The 1977 figures represent tentative apportionment of the amount requested.

2/ Amounts reflected in this column are actual obligations including non-recurring "B" funds released to some States after they received their notification of allocation of funds.

3/ Excludes $1,500,000 for program support.

Allocations of Grants for Crippled Children's Services

Actual and Estimated Awards [1]
Fiscal Years 1975-7

State	1975 Actual [2]	1976 Appropriation	1977 Request
Alabama	$1,338,000	$1,527,500	$889,500
Alaska	192,000	202,900	176,100
American Samoa	81,000	147,600	144,400
Arizona	579,000	610,500	372,700
Arkansas	783,000	925,100	540,700
California	2,845,000	3,468,400	2,106,100
Colorado	564,000	656,000	390,100
Connecticut	567,000	640,800	406,500
Delaware	224,000	236,500	193,300
District of Columbia	245,000	248,400	199,600
Florida	1,547,000	1,829,800	1,106,000
Georgia	1,597,000	1,916,700	1,133,700
Guam	165,000	158,700	152,100
Hawaii	254,000	277,700	219,000
Idaho	340,000	347,200	218,700
Illinois	1,893,000	2,231,500	1,307,900
Indiana	1,515,000	1,789,800	1,055,700
Iowa	897,000	1,039,800	585,200
Kansas	577,000	674,400	391,600
Kentucky	1,272,000	1,464,000	848,100
Louisiana	1,314,000	1,578,700	907,700
Maine	259,000	452,800	267,500
Maryland	861,000	1,005,500	596,200
Massachusetts	980,000	1,232,300	727,000
Michigan	2,121,000	2,457,600	1,446,600
Minnesota	1,103,000	1,299,000	752,900
Mississippi	1,073,000	1,253,800	741,600
Missouri	1,206,000	1,416,000	842,300
Montana	291,000	299,000	209,000
Nebraska	439,000	508,700	299,600
Nevada	237,000	230,100	193,500
New Hampshire	297,000	298,700	213,400
New Jersey	1,116,000	1,275,800	771,500
New Mexico	411,000	468,400	279,600
New York	2,594,000	3,220,500	1,968,800

Allocations of Grants for Crippled Children's Services (Cont'd)

Actual and Estimated Awards 1/
Fiscal Years 1975-7

State	1975 Actual 2/	1976 Appropriation	1977 Request
North Carolina	$2,029,000	$2,412,500	$1,407,100
North Dakota	256,000	275,300	199,600
Ohio	2,517,000	3,000,500	1,747,300
Oklahoma	738,000	886,500	532,900
Oregon	607,000	712,400	421,800
Pennsylvania	2,814,000	3,333,000	1,924,600
Puerto Rico	1,484,000	1,925,300	1,255,900
Rhode Island	296,000	286,600	219,700
South Carolina	1,132,000	1,360,300	797,800
South Dakota	258,000	318,600	204,000
Tennessee	1,367,000	1,624,300	929,400
Texas	2,859,000	3,422,200	2,034,000
Trust Territory	165,000	164,600	155,500
Utah	341,000	427,000	268,100
Vermont	249,000	254,200	184,300
Virgin Islands	166,000	154,000	150,200
Virginia	1,402,000	1,631,700	956,700
Washington	813,000	959,100	562,300
West Virginia	755,000	870,700	502,200
Wisconsin	1,324,000	1,579,400	905,500
Wyoming	188,000	199,100	173,900
Total distribution by formula 1/	53,537,000	63,187,500	38,187,000
Special projects for mentally retarded children	4,999,000	5,000,000	3,600,000
Other special projects	6,357,000	8,312,500	4,941,000
Total	64,893,000	76,500,000	46,728,000

1/ (a) One-half of the amount appropriated for each year is apportioned among States on the basis of a uniform grant of $70,000 and an additional grant in proportion to the number of children under 21 years in the State. Amounts awarded must be matched dollar for dollar.

(b) The remaining half, after being reduced by the amounts reserved for the two categories of special projects, is apportioned by formula. Each State receives an amount which varies directly with the number of children under 21 years in urban and rural areas in the State and varies inversely with State per capita income. No State receives less than a specific minimum amount and children in rural areas are given twice the weight of those in urban areas.

(c) The 1977 figures represent tentative apportionment of the amount requested.

2/ Amounts reflected in this column are actual obligations including non-recurring "B" funds released to some States after they received their notification of allocation of funds.

Supplemental Allocations of Grants for Maternal and Child Health Services

Estimated Awards
Fiscal Years 1975-7

States	1975 Actual	1976 Appropriation	1977 Request
Alabama	$202,836	$21,657	---
Alaska	---	---	---
American Samoa	---	---	---
Arizona	166,259	---	---
Arkansas	---	---	---
California	---	---	---
Colorado	1,567,721	2,019,260	---
Connecticut	295,159	353,388	---
Delaware	---	---	---
District of Columbia	3,282,814	4,437,134	---
Florida	968,979	685,700	---
Georgia	---	---	---
Guam	---	---	---
Hawaii	327,257	554,847	---
Idaho	---	---	---
Illinois	2,930,725	3,403,431	---
Indiana	---	---	---
Iowa	---	---	---
Kansas	---	---	---
Kentucky	---	---	---
Louisiana	---	---	---
Maine	---	---	---
Maryland	2,299,237	2,969,732	---
Massachusetts	1,489,285	1,624,126	---
Michigan	480,528	279,000	---
Minnesota	---	---	---
Mississippi	---	---	---
Missouri	97,755	---	---
Montana	---	---	---
Nebraska	664,143	729,320	---
Nevada	57,030	24,448	---
New Hampshire	107,631	---	---
New Jersey	---	---	---
New Mexico	---	---	---
New York	7,379,303	8,398,938	---

Supplemental Allocations of Grants for Maternal and Child Health Services
(Cont'd)
Estimated Awards
Fiscal Years 1975-7

States	1975 Actual	1976 Appropriation	1977 Request
North Carolina	---	---	---
North Dakota	---	---	---
Ohio	$239,138	---	---
Oklahoma	---	---	---
Oregon	---	---	---
Pennsylvania	---	---	---
Puerto Rico	1,845,834	$1,031,802	---
Rhode Island	---	---	---
South Carolina	---	---	---
South Dakota	---	---	---
Tennessee	---	---	---
Texas	163,829	---	---
Trust Territory	---	---	---
Utah	---	---	---
Vermont	---	---	---
Virgin Islands	434,537	607,500	---
Virginia	---	---	---
Washington	---	---	---
West Virginia	---	---	---
Wisconsin	---	---	---
Wyoming	---	---	---
Total	$25,000,000	27,140,283	---

New Positions Requested

	Grade	1977 Number	Annual Salary
National Health Service Corp			
Medical Officer	GS-13	3	$82,725
Dental Officer	GS-13	2	55,150
Nurse practitioner	GS-9	9	115,884
Nurse practitioner	GS-7	11	119,462
Subtotal		25	373,421
Medical Officer	Full	35	542,920
Dental Officer	Full	8	124,096
Medical Officer	Senior Assistant	40	570,720
Dental Officer	Senior Assistant	13	185,484
Commissioned Nurse Officer	Senior Assistant	4	57,072
Subtotal		100	1,480,292
Total New Positions		125	1,853,713
Professional Standards Review Organizations			
Public Health Program Specialist.	GS-15	1	$ 31,309
Medical Care Administrator	GS-14	1	26,861
Nurse	GS-14	1	26,861
Public Health Program Specialist.	GS-14	1	26,861
Public Health Program Specialist.	GS-13	5	114,530
Medical Care Administrator	GS-13	4	91,624
Health Economist	GS-13	1	22,906
Public Health Program Specialist.	GS-12	10	193,860
Public Health Program Specialist.	GS-11	5	81,275
Program Analyst	GS-9	3	40,446
Clerical Assistant	GS-7	3	33,138
Secretary	GS-6	2	19,892
Clerical Assistant	GS-5	5	44,625
Clerk Typist	GS-4	6	47,856
Total New Positions		48	802,044
Total New Positions All Activities		173	2,655,757

Transition Quarter Analysis

	Budget Authority by Activity	
	1976 Estimate	Transition Quarter
Community health services:		
a) Community health centers	$196,648,000	$48,000,000
b) Comprehensive health grants to States	90,000,000	22,500,000
c) Maternal and child health:	295,700,000	65,316,000
1) Grants to States	2,500,000	---
2) SIDS	23,708,000	14,909,000
3) Research and training	321,908,000	80,225,000
Subtotal	100,615,000	7,000,000
d) Family planning	25,000,000	3,500,000
e) Migrant health		
f) Health maintenance organizations:	15,000,000	4,043,000
1) Grants and Contracts	(15,727,000)	
	3,612,000	957,000
2) Program support	18,612,000	5,000,000
Subtotal	(19,339,000)	
g) National health service corps	15,000,000	8,662,000
	(20,000,000)	
h) Hypertension	3,750,000	---
i) Home health services	3,000,000	---
j) Hemophilia	3,000,000	---
Subtotal	777,533,000	174,887,000
	(783,260,000)	(174,887,000)
Quality assurance:	---	---
a) Medical care standards	(5,187,000)	(1,764,000)
b) Professional standards review organizations	26,448,000	7,754,000
	(47,582,000)	(13,011,000)
Subtotal	26,448,000	7,754,000
	(52,769,000)	(14,775,000)
Patient care and special health services:		
a) Patient care	116,164,000	30,680,000
	(136,056,000)	(35,659,000)
b) Coast Guard medical services	---	---
c) Federal employee health	606,000	168,000
	(6,830,000)	(1,770,000)
d) Payment to Hawaii	1,200,000	300,000
Subtotal	117,970,000	31,148,000
	(144,086,000)	(37,729,000)
Emergency medical services	37,025,000	1,000,000
Buildings and facilities	---	---
	(13,815,000)	(---)
Program management	30,663,000	7,998,000
Total	989,639,000	222,787,000
	(1,061,618,000)	(236,389,000)

Explanation

The Community Health Center's program within the Bureau of Community Health Services will require $48,000,000 in the transition quarter. This amount is necessary due to the large number of project grants that require funding during this three month period. Fifty-two community health centers will receive Federal funds to support ambulatory health care service programs. This $22,500,000 for the Comprehensive health grants to States is one-quarter of the $90,000,000 request for the total year. The $65,316,000 for Maternal and Child Health is based on the funding of 151 project grants and the distribution to the States of foraula grant funds. In addition, the $14,909,000 for MCH research and training is based on the funding of eight research and 26 training projects. As estimated $7,000,000 is necessary for Family Planning activities during this three-month period. This amount is based on continuing to fund 16 ongoing family planning grants. $3,500,000 will be needed by the Migrant Health program to continue the funding of 16 projects. The Health Maintenance Organizations' request for $5,000,000 is based on providing funds to five developmental projects totaling $4,043,000 and $957,000 for program support. An estimated $8,662,000 is requested for the National Health Service Corps for the transitional period. This amount is due to the estimate being based on 676 positions rather than 405 positions and the fact that a large number of physicians will be eligible for the commissioned officer's bonus pay.

The Professional Standards Review Organization program within the Bureau of Quality Assurance will require $7,754,000 in this three-month period. This amount will be used to meet commissioned officer's bonus pay requirements and for anticipated contracts which will need refunding during the transition quarter.

The Bureau of Medical Services' Patient Care activity will require $30,680,000 between July 1, and September 30, 1976. This amount is needed for commissioned officer's pay, increases in contract medical care, within grade and longevity increases, and for changes in rates such as utilities and postage. An estimated $168,000 is needed for the Federal Employee Health program. This amount is required to carry out this program during the transition quarter, plus funds for commissioned officer's bonus pay and within grade increases. The $300,000 for Hawaii is simply 25 percent of the total year funding requirement. An estimated $1,000,000 is required for the Emergency Medical Services program. This amount will be used to fund thirty grants and contracts which will receive Federal funds. Finally, a total of $7,998,000 is needed for Program Management activities during the transition quarter. This amount, besides being required to carry out the normal program management functions, is needed to meet such mandatory cost increases such as commissioned officers' bonus pay, within grade and longevity increases, and for one extra day of pay.

CENTER FOR DISEASE CONTROL

STATEMENT OF DR. DAVID J. SENCER, DIRECTOR, CENTER FOR DISEASE CONTROL

ACCOMPANIED BY:

DR. JOHN F. FINKLEA, EXECUTIVE OFFICER, CENTER FOR DISEASE CONTROL

JAMES D. BLOOM, EXECUTIVE OFFICER, CENTER FOR DISEASE CONTROL

CLAUDE PICKELSIMER, DIRECTOR, FINANCIAL MANAGEMENT OFFICER, CENTER FOR DISEASE CONTROL

CHARLES MILLER, DEPUTY ASSISTANT SECRETARY, COMPTROLLER

TOP PRIORITY FOR CENTER BUDGET

Senator MAGNUSON. Next, Dr. David Sencer, the Director of the Center for Disease Control, will present testimony on the proposed budget request.

Unfortunately, many of the preventive health programs are not authorized. Such programs as immunization, V.D. control and lead-based paint poisoning prevention all lack authorizing legislation.

For the programs which do contain the proper legislation, severe cutbacks are proposed. A good example of this is the 20-percent reduction which you are proposing for rat control.

The Center for Disease Control is one of the top priorities of this committee because of its emphasis on preventive medicine.

BIOGRAPHICAL SKETCH

Dr. Sencer, we will place your biographical sketch in the record at this point, after which you may proceed with your statement.

[The biographical sketch follows:]

Biographical Sketch

NAME	:	David J. Sencer, M.D.
POSITION	:	Director, Center for Disease Control
BIRTHPLACE AND DATE	:	Grand Rapids, Michigan, November 10, 1924
EDUCATION	:	Wesleyan University, Middletown, Connecticut, 1944 University of Mississippi, 1946 University of Michigan, 1951, M.D. University Hospital, Ann Arbor, Michigan, 1951, Internship Internal Medicine Residency, 1954 Harvard University School of Public Health, 1958, M.P.H.
EXPERIENCE		
1966-Present	:	Director, Center for Disease Control, Atlanta, Georgia
Jan. 1973-May 1973	:	Acting Administrator, Health Services and Mental Health Administration
1964-1966	:	Deputy Chief, Center for Disease Control, Atlanta, Georgia
1960-1964	:	Assistant Chief, Communicable Disease Center, U.S. Public Health Service, Atlanta, Georgia
1959-1960	:	Program Officer, Bureau of State Services, U.S. Public Health Service, Washington, D.C.
1955-1959	:	Medical Officer in Charge, Muscogee County TB Field Research Facility, DSPBS, Columbus, Georgia
1955	:	Medical Consultant, Tuberculosis Program, U.S. Public Health Service
TEACHING APPOINTMENTS	:	Visiting Lecturer on Tropical Public Health, Harvard University School of Public Health, Boston, Massachusetts Clinical Professor of Prevention Medicine, Emory University School of Medicine, Atlanta, Georgia
ASSOCIATION MEMBERSHIPS	:	American Medical Association American Public Health Association American Thoracic Society American Society of Tropical Medicine and Hygiene Delta Omega Georgia Tuberculosis Association International Epidemiological Association Diplomate, American Board of Preventive Medicine Fellow, American College of Preventive Medicine Board of Governors of the U.S.-Israel Binational Science Foundation

SCIENTIFIC PUBLICATIONS:

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Sencer, David J., Dull, H. Bruce and Langmuir, Alexander D.: Epidemiologic basis for eradication of measles in 1967. A Statement by the Public Health Service. Public Health Rep. 82: 253-256, 1967.

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Mosley, J.W. and Sencer, D. J.: Isoniazid toxicity. JAMA 218:447, 1971.

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Symp. Series Immunobiol, Standard. Vol. 20. Basel/New York, Karger, 1973, pp. 244-251.

STATEMENT OF DR. DAVID J. SENCER

Senator MAGNUSON. Please proceed with your statement, Dr. Sencer,

Dr. SENCER. Mr. Chairman, members of the committee, it is a pleasure to present the budget for preventive health services for fiscal year 1977.

The Center for Disease Control is the Nation's primary Federal focus for programs directed at preventing diseases and their consequences, beginning with a mandate for control of just one disease—malaria—in the 1940's. CDC's mission has been broadened so that today it includes a variety of programs all directed at protecting the health of the American public.

To summarize our activities, I have categorized them into five major areas: (1) investigation, surveillance, and control of disease; (2) activities to improve the safety and health of workers; (3) improvements in disease control techniques; (4) health education, and (5) laboratory improvement.

INVESTIGATION, SURVEILLANCE AND CONTROL OF DISEASE

The major portion of the preventive health services budget is directed at investigation, surveillance, and control of disease. Working with State and local health departments, we maintain active surveillance and control programs for more than 30 diseases.

During 1975, our staff conducted more than 1,500 separate investigations of disease conditions. These investigations ranged from national epidemics involving thousands of people to a single occurrence of a disease not common to this country, such as leishmaniasis or Chagas' disease.

The arrival in this country of more than 100,000 Vietnamese refugees required a major effort by CDC in 1975. We immediately established a surveillance program at camps in the Far East and in this country to assure that the conditions of camp life would not cause disease, and that emerging problems were promptly corrected. Arriving refugees were screened for personal and potential public health problems. Children were immunized against the vaccine-preventable diseases. We found few unexpected health problems among the refugees and were able to assure the American public that these new citizens posed no more of a problem to the public health than any of the other thousands of immigrants who come to this country every year. We are proud that 230 of our staff actively worked for varying periods of time in this humanitarian effort.

MOSQUITO-BORNE ENCEPHALITIS

Cases of mosquito-borne encephalitis reached an all-time high in the United States during 1975. Approximately 2,000 cases and 100 deaths were reported. Activity was the most widespread ever, as 35 States and the District of Columbia had cases of encephalitis. Four of these States, Illinois, Indiana, Mississippi, and Ohio, had more than 100 cases. CDC provided technical assistance in identifying suspect cases and in controlling the mosquitoes which transmit the disease. We

are continuing our investigation of this year's epidemic, so that appropriate control measures can be recommended for future years.

HOSPITAL-ACQUIRED INFECTIONS

Hospital-acquired infections continue to be a major problem. We estimate that 1½ million patients spend an additional 7 days in a hospital each year because of such an infection. The cost is a staggering $1 billion. Now underway is a major study to determine which hospital infection control procedures are most effective. This "Study on the Efficacy of Nosocomial Infection Control" will be largely complete during fiscal year 1977. It will give us information we need to assist hospitals in developing effective infection surveillance and control procedures to reduce the human suffering and economic loss resulting from this problem.

BIRTH DEFECTS

During this past year, we have expanded birth defects monitoring to a national scope. This program will now cover approximately 1 million births a year. It should give us a data base large enough to uncover changes in the incidence of birth defects and the types of environmental or other exposure which might be responsible.

DISEASES OF YOUNG

Progress continues to be made in preventing the dread diseases of the young, such as polio, diphtheria, tetanus, whooping cough, rubella, mumps, and measles. Reported cases of measles remained below 25,000 for the past 2 years—a sharp decline from the 200,000-plus cases occurring less than 10 years ago. The number of cases of congenital rubella reached an alltime low. Only six cases of polio were reported in 1975, compared to thousands of cases and deaths some 20 years ago.

LEAD POISONING

More than 440,000 children were tested for excess lead in their bodies. Twenty-eight thousand of those tested had potentially dangerous levels of lead and were provided with medical and environmental services to protect them from the serious consequences of lead poisoning. In cooperation with the American Academy of Pediatrics, lead screening guidelines were developed for the early periodic screening, diagnosis and treatment (EPSDT) programs. While a national figure on the number of children screened under EPSDT programs is not available, we are aware of at least 275,000 children who were tested for excess lead. Seventeen States now require a screening test for lead under EPSDT, and 32 States have a reimbursement procedure. At the State and local levels, we are encouraging maternal and child health programs, Head Start programs, neighborhood health centers, and children and youth projects to do lead screening where appropriate.

RAT CONTROL PROGRAM

Rat control programs were carried out in the neighborhoods of more than 5½ million urban Americans. In these neighborhoods, 64 percent of the blocks were certified as being essentially rat free.

VENEREAL DISEASES

The incidence of gonorrhea and syphilis remain at unacceptable high levels. Gonorrhea is still the most frequently reported infectious disease in this country, although the percentage of increase has been slowed. More than 8 million women were tested for gonorrhea last year. Of these, 375,863, or 4.2 percent, had gonorrhea and were treated. Early identification makes it possible to prevent further spread of the disease.

Syphilis increased slightly during the past year, although major increases were confined to a few areas of the country and largely limited to males. Major efforts are underway to tailor venereal disease control services to assure acceptance by the homosexual population.

We will continue to generate other sources of support for control programs directed at the vaccine-preventable diseases, veneral diseases, rats, and lead poisoning. An example of such additional support is the $4,847,228 made available in fiscal year 1976 to grantees from the Job Opportunities program of the Public Works and Economic Development Act.

HEALTH AND SAFETY OF WORKERS

The Federal initiative in occupational health is a very old one. It began in 1914 with the establishment of the Office of Industrial Hygiene and Sanitation "to study the health problems in the Nation's expanding industrial economy."

Increased impetus to improving conditions for workers was given in 1970, with the passage of the Occupational Safety and Health Act. The National Institute for Occupational Safety and Health (NIOSH) was created by this act as the principal Federal agency engaged in research to eliminate job hazards for America's working population. It is NIOSH's primary responsibility to identify occupational safety and health hazards and to develop recommendations regarding new hazards and changes in existing regulations. During 1975, significant progress was made by NIOSH in accomplishing this mission.

NIOSH transmitted nine recommended standards to the Department of Labor. These standards evaluated the occupational health hazards posed by benzene, chloroform, cotton dust, silica, ammonia, fluorides, xylene, arsenic, and labeling of hazardous materials. Laboratory research in support of criteria development for the standards recommendation program is directed at 32 hazardous substances and physical agents. Industrywide studies in support of the standards recommendation program are being conducted in 37 different industries

NIOSH completed 65 health hazard evaluation reports. Such evaluations are designed to determine if substances normally found in a

specific place of employment have potentially toxic effects. They are made on request from an employer or a representative of employees.

Coal miner chest X-rays for 55,000 workers were processed as part of the periodical examination program mandated by the Federal Coal Mine Health and Safety Act of 1969.

Training in occupational safety and health was given to 1,200 individuals as part of the NIOSH reimbursable short-term training program. Development continued on the packaging of courses for presentation by others as well as development of correspondence courses.

Tests were done on 272 different models of personal protective equipment.

Significant progress has been made in the development of an occupational carcinogenesis program within NIOSH. In cooperation with the National Cancer Institute, we have initiated epidemiologic studies involving possible environmental or occupational exposures and the excess lung, mouth, and throat cancer mortality rates noted in selected Georgia and South Carolina counties. It is significant that the number of investigations by CDC epidemiologists of diseases caused by environmental factors such as lead and kepone—increased three fold this past year.

NIOSH personnel in Cincinnati are being moved from the unsatisfactory facilities we have been occupying to two new locations in that city. The majority of our operations in Cincinnati will be moved by spring.

During 1976, NIOSH will recommend to the Department of Labor criteria on 24 hazardous substances that impinge on the health of 1.7 million people in the workplace. The budget will also permit NIOSH to carry out increased research on hazardous substances and harmful physical agents and allow intensified efforts to identify and prevent cancer of occupational origin through field studies and epidemiologic investigations in 40 high-risk industries, as compared with 37 in 1976.

DEVELOPMENT OF NEW DISEASE CONTROL TECHNIQUES

A major activity supported under the preventive health service budget is a program to improve techniques used to control diseases.

A testing procedure is of little value if it is too expensive or not generally available; nor can a strategy for containment of disease be effective if those involved are not aware of the strategy. It is CDC's mission to foster the development of new tests and procedures and then promote rapid and widespread use of the improved techniques through training programs, workshops, publications, and other outreach efforts.

Areas in which are currently attempting to improve laboratory and diagnostic proficiency include: blood lead determination, especially in children; blood levels of digoxin, a drug used in heart disease therapy, which must be continually monitored; alkaline phosphatase which is important in the diagnosis of bone, liver and prostatic cancer; and magnesium deficiencies which are of increasing clinical importance. In hematology, a new method for evaluating the technologist's ability to correctly read differential blood films will be employed. Review of the competency of cytotechnologists in screening vaginal

and cervical smears for cancer will continue as will a survey of national competency in identifying carcinoembryonic antigen (CEA) in serum, a relatively new test used in cancer control.

During 1975, the progressive increase in gonococcal resistance to penicillin and tetracyline was halted for the first time since it began 25 years ago. This was accomplished because of widespread use of the CDC treatment schedules for gonorrhea.

A new strategy for controlling measles outbreaks is now being field tested in one section of the country. The strategy, which is based on the procedures we have used in the worldwide war on smallpox, stresses early identification and control If successful, it will—in combination with basic immunization programs—become the national strategy for measles control.

New serologic tests have been developed which permit identification of individuals with hepatitis. These new tests were made possible because scientists perfected a technique to recover hepatitis A virus from a common source outbreak and visualize it with an electron microscope. These accomplishments are necessary steps along the road to development of an improved test for hepatitis A and eventually a vaccine.

The emergence of different influenza strains throughout the world is monitored by the CDC's World Health Organization Collaborating Center for Influenza in cooperation with collaborating laboratories in 69 countries. Reagents distributed to nearly 200 laboratories provide uniformity in the diagnosis and analysis of influenza. To update methodology in collaborating laboratories, CDC conducted a workshop for senior scientists from eight countries in the Southeast Asia and the western Pacific regions. The worldwide surveillance and uniform analysis of influenza isolations provides essential data for the formulation of current influenza vaccines in this and other countries. A large field trial comparing live and inactivated vaccines was conducted in nearly 1,000 volunteers during 1975. Both vaccines were effective in reducing the illness attack rate during an epidemic of influenza in the study population. Investigations of the characteristics of other live influence virus candidate vaccine strains are in progress.

HEALTH EDUCATION

Thousands of deaths and illnesses occur in the United States each year because the American people are not fully aware of the important role lifestyle can play in maintaining or harming health. Many premature illnesses and deaths can be prevented by decisions individuals and communities can make to protect their own health.

To assure that all Americans can make informed health decisions, and to motivate them to take action to improve their health status, CDC provides coordination for a national health education program. The program encourages broad use of the Nation's health care system in its many ramifications so as to prevent unnecessary disabilities or deaths.

Research, demonstration, or evaluation projects are being carried out in cooperation with neighborhood health centers, schools, Agricultural Extension Services and other existing facilities. Other projects involve programs with the newly formed "National Center for Health Educa-

tion," comprised of private health groups, and the continuation of surveys of smoking prevalence among teenagers, adults, and health professionals.

In 1976, a desk reference containing a summary of the significant scientific evidence and health problems related to cigarette smoking will be developed. It will provide a valuable tool for health professionals, researchers, and others, involved in managing health problems related to smoking.

LABORATORY IMPROVEMENT

More than 4 billion clinical tests are done annually in the laboratories of this Nation. The accuracy of these tests determines, in many cases, the quality of diagnosis, preventive care, or treatment the American citizen will receive. CDC administers a multifaceted program to improve the Nation's more than 14,000 clinical laboratories and to upgrade the quality of the tests and materials used by these laboratories. Our activities in laboratory technology development and transfer were summarized earlier in this statement.

In addition, CDC has, since passage of the Clinical Laboratory Improvement Act, utilized the regulatory process as another means of accomplishing laboratory improvement. Since that time, constant efforts have been made to meld the CLIA and the medicare laboratory certification process so that the programs are uniform and nonduplicative. In the interest of economy and effectiveness and to insure maximum uniform coverage of the Nation's approximately 14,000 clinical laboratories, CDC has entered into an agreement with the Social Security Administration and the Health Service Administration which provides for an integration of functions. CDC assumes the responsibility for oversight monitoring of the effectiveness of each State program and other approved programs, including those of the College of American Pathologists, and the Joint Commission on the Accreditation of Hospitals. States will be expected to provide or approve a proficiency testing program equivalent to the performance evaluation program applied to CLIA laboratories. CDC will provide proficiency testing for CLIA and medicare laboratories where States do not have equivalent programs. In the event that the monitoring program finds some part of a State evaluation program less stringent than that of CLIA, CDC will directly evaluate all medicare and CLIA laboratories in that State until the State evaluation program can be upgraded. CDC will continue to initiate scientific and technical standards for application to both CLIA and medicare laboratories in the areas of personnel, quality control, and proficiency testing.

Additional resources in 1977 would allow CDC to carry out its responsibilities under these agreements, including increased onsite surveillance of laboratories, proficiency testing services for 1,500 laboratories not presently covered, and increased assistance in the development of State training capabilities. The center also would provide financial assistance to States which have demonstrated a real interest in upgrading their instrastate programs. Such assistance, when extended to all States, would provide for the full gamut of laboratory improvement activities from regulatory monitoring to technical train-

ing and consultation designed to insure adherence by clinical laboratories to minimal levels of performance, regardless of size, type or geographical location.

Finally, I would like to bring you up to date on the worldwide effort to eliminate smallpox. While our activities against this disease have been only partially funded by this appropriation, this committee and its members have been most supportive of our efforts. Within the past few months, smallpox has been eradicated from India and Bangladesh. This dread disease is now confined to the central Ethiopian highlands where accelerated efforts are underway to bring about the demise of smallpox in 1976.

Mr. Chairman, I will be happy to answer any questions that you or other members of the committee may have.

LACK OF AUTHORIZING LEGISLATION

Senator MAGNUSON. Unfortunately, three of your most important programs are not authorized—the venereal disease program, immunizations, and lead-based paint poisoning. What is happening to these programs and community projects because of this authorization problem?

Dr. SENCER. These programs are being continued in 1976 under the continuing resolution at the level of the administration's budget request.

CENTER FOR DISEASE CONTROL—NEW STRAIN OF VENEREAL DISEASE

Senator MAGNUSON. I understand that a new strain of venereal disease has recently appeared which is resistant to penicillin. Has an effective treatment been devised?

Dr. SENCER. Perhaps you are referring to herpes simplex type 2 virus infections. This disease, though not new, is spread by sexual intercourse and is increasingly being recognized as a public health problem. To date there is no therapy which has been demonstrated to be effective in hastening the healing of active lesions or in preventing their recurrence. The Department is stepping up its research efforts to define the magnitude of this problem, to understand the basic biology of host-organism interaction, and to discover an effective therapy.

I might add that the increasing resistence of gonorrhea to penicillin and other antibiotics has been halted as a result of widespread acceptance of therapy schedules which were recommended by Center for Disease Control in 1972.

COST OF TRAINING

Senator MAGNUSON. What reaction have you had from State and local governments in terms of your new requirement for full reimbursement of training costs at the Center?

Dr. SENCER. With the passage of the 1976 Appropriations Act, we have required full reimbursement of costs for training at the Center. Not enough time has passed to provide concrete data.

An informal telephone survey of 11 randomly selected State health agencies last April disclosed that under present economic conditions,

most States have experienced reduction in their travel budgets. The added costs of tuition charges as well as the general increase in the cost of travel would greatly increase the cost of training each student. There was unanimous agreement that participation by State employees in these courses would be virtually eliminated. These States have relied heavily on the Center for Disease Control headquarters courses to provide specialized training for their employees—training available at no other institution in the Nation. It is unfortunate that the States which perhaps need the training most are the ones that can least afford the additional cost.

LABORATORY IMPROVEMENT

Senator MAGNUSON. I see that you are requesting an increase of over $4 million for laboratory improvement. Just what will these funds be used for?

Dr. SENCER. The increased funds and positions earmarked for laboratory improvement activities for fiscal year 1977 will provide for upgrading the Center's resources to carry out responsibilities under the agreement with the Social Security Administration and Health Services Administration for applying a single uniform set of standards in a consistent manner to all federally monitored laboratories. This includes increasing the number of laboratories directly inspected by Center for Disease Control examiners under the monitoring portion of the agreement from 900 to 1,400 per year; increasing number of laboratories covered by direct proficiency testing from 2,600 to 3,200 per year; and providing technical and management consultation to all State health departments in developing their laboratory improvement activities.

In addition, money is provided for developmental assistance contracts for State laboratory improvement activities in order to support a full range of laboratory certification services at the State level, including onsite inspection, proficiency testing of laboratory performance, as well as remedial training. Assuming that medicare laboratory standards for independent laboratories, which are identical to those of the Clinical Laboratories Improvement Act of 1967, are applied to hospital laboratories as well, and that a national health insurance plan will be introduced in this decade, with its implications for increased utilization of laboratory diagnostic services, a modest Federal investment in the development of State laboratory capabilities is extremely critical at this time. This developmental assistance will be directed toward those States which have demonstrated interest in and basic capability for carrying out their own laboratory improvement program. Developmental assistance contracts will be awarded to States which have been evaluated by Center for Disease Control staff on the basis of criteria which are being developed.

PREVENTION

Senator MAGNUSON. The committee has constantly stressed the high priority we place on prevention programs, but it seems as if the Department of Health, Education, and Welfare is not stressing this

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enough. What do you think should be done to improve our prevention effort?

Dr. SENCER. The Center for Disease Control carries out a multiphasic prevention effort in cooperation with State and local health agencies and other health organizations. New program effort in fiscal year 1977 will be devoted to the occupational carcinogen program for protection of workers exposed to cancer-causing agents in the workplace. In fiscal year 1977, the Center will substantially expand its proficiency testing and onsite laboratory evaluations to larger numbers of laboratories and a wider range of procedures. Selection will be based on volume, difficulty, and importance of the procedure such as blood lead determinations in children. Health education will be a significant element of a comprehensive program of prevention at the Center for Disease Control with emphasis on prevention as a means of improving the Nation's health and reducing the costly utilization of medical care.

ACCIDENT PREVENTION ACTIVITIES

Senator MAGNUSON. Last year the Senate report directed you to move ahead in the area of accident prevention programs. Exactly what has been done to follow this directive?

Dr. SENCER. Since most deaths and disability from accidents are preventable, data suggests that much improvement in the area of accident prevention could come from individual action. We recognize that the fatalities and permanent disabilities resulting from accidents in the occupational environment has not decreased over the past 5 years. At Dr. Cooper's request, we prepared an injury control program proposal which has been reviewed by the Public Health Service, and their comments have been provided to us. We anticipate that the Public Health Service fiscal year 1978–1982 forward plan will include a new comprehensive initiative on injury control including occupational safety.

HEALTH EDUCATION

Senator MAGNUSON. Please give us some good, practical examples of what you are doing in health education.

Dr. SENCER. One of the primary recommendations of the 1973 report of the President's Commission on Health Education was that a nonprofit health education organization be established in the private sector. The National Center for Health Education was officially established on October 1, 1975. The National Center was established subsequent to the Center for Disease Control's contract with the National Health Council to explore the feasibility and recommend the functions, structure, and organizational nature of a privately based health education center. We think its establishment is particularly noteworthy and holds great promise as the primary catalyst and facilitator in the private sector for health education of the public. The center for Disease Control has begun to cooperate with the National Center in selected program areas of mutual concern to the private sector and the Federal Government but which are better managed in the private sector.

The Center for Disease Control is interested in developing and evaluating innovative methodologies to reach certain groups which suffer disproportionately high rates of morbidity and mortality. A good example is the pilot project with end-stage renal disease institutions in Seattle, Kansas City, and Atlanta designed to increase the supply of cadaveric kidneys for transplantation. Surveillance and operational procedures will be developed to identify potential donors as they come to medical attention. Health education outreach methods will be developed to inform persons of the need for kidneys and the procedures for donating them. If these demonstration projects are successful, the approaches will be adapted for introduction in other areas of the country.

The Center is assisting the Department, through its intradepartmental panel, to develop health education program objectives and priorities. It is coordinating the work of three task forces which are developing recommendations for specific program activities in the areas of target populations, research and evaluation, and reimbursement and insurance. The Center is also conducting health education demonstration projects at the community and national levels to develop and evaluate programs and methodologies designed to reach specific target populations. These projects include school health curriculum programs in 175 school districts for youths in grades 4 through 7, and programs designed to provide health education services to high health risk groups such as rural populations in Arkansas; rural, barrio, and Indian groups in New Mexico; blacks in Alabama; the handicapped in Texas; and family planning patients in New Jersey.

The Center is conducting research projects to provide information on general adult, and physician, nurse, dentist, and pharmacist attitudes and behavior regarding cigarette smoking for the development of health education and smoking prevention programs. In addition, the Center for Disease Control continues to provide the annual report to Congress on the health consequences of smoking.

Senator MAGNUSON. What are you requesting for this program in fiscal 1977 compared to fiscal 1975?

Dr. SENCER. The Center's health education budget for fiscal 1975 was $3,027,000 and the request for fiscal 1977 is $3,013,000.

NEW PROGRAMS

Senator MAGNUSON. What new surveillance control and prevention activities are you proposing in fiscal 1977?

Dr. SENCER. Our largest surveillance effort in fiscal year 1977 will be the study of the efficacy of nosocomial infection control, a large-scale retrospective study designed to determine accurately the current prevalence of hospital-acquired infections and the effectiveness of infection control in terms of improved patient health, reduced hospital stay, and lowered health costs.

Emphasis on occupational carcinogenesis will focus on particular occupational groups experiencing unexpected rates of cancer and particular substances or agents found in the workplace.

With Ethiopia, the only country now reporting cases, projected to become free of smallpox this year, surveillance to insure that smallpox

has in fact been eradicated must be made. The Center for Disease Control will furnish technical advisors through the World Health Organization to assist in this historic endeavor.

In fiscal year 1977, our operational research will include new control strategies for sexually transmitted diseases and improved preventive regimens in tuberculosis. Also, the Center will continue to refine immunization control strategies in fiscal year 1977, with special emphasis on an intensive measles containment program designed to interrupt transmission before the disease can spread.

RAT CONTROL

Senator MAGNUSON. Now that we finally have the proper legislation for rat control, what initiatives are you planning?

Dr. SENCER. We are placing more emphasis now than in the past on developing State level involvement in rat control. We think that State level financial and technical involvement in rat control activities is essential if there is to be a sustained, long-term commitment to rat control in urban areas. It is very difficult for the Federal Government to try to work directly with each city in the country, and we must help State health agencies rebuild strong programs in rat control and in other areas of environmental health and sanitation.

LOW BUDGET

Senator MAGNUSON. Considering your low-budget request for rat control programs, will all of the present programs be able to continue at full levels?

Dr. SENCER. At the budget request for rat control programs, 50 of the current 64 program communities will receive Federal support for rat control activities in 1976, although at reduced levels. Project supported rat control activities will be concentrated in blocks that have a major rat problem. Locally supported surveillance and remedial activities will be provided for those blocks which have reached a "maintenance" stage and are dropped from approved Federal target areas. We are expecting the remaining 14 communities to maintain their programs without grant assistance.

RAT POPULATION

Senator MAGNUSON. Is the rat population of the United States down? If not, what would it take to mount a successful effort in this area?

Dr. SENCER. There is no reliable estimate available on the size of the rat population in the United States. I do know that 64 percent of the blocks where intensive effort has been underway in currently supported programs are essentially rat free. At the start of the program, 16 percent of the houses in these same blocks were rat infested. However, there are approximately 250 additional urban communities which may have serious rat problems. As I indicated earlier, it would be costly, and in the long run ineffective, for the Federal Government to attempt to solve this problem by working directly with each of these 250 cities.

We need to address ourselves to helping States develop strong programs in all areas of environmental health if there is to be a long-term meaningful attack on the residental rat problem.

NATIONAL INSTITUTE FOR OCCUPATIONAL SAFETY AND HEALTH

Senator MAGNUSON. What have the major activities of the National Institute for Occupational Safety and Health been in the past year?

Dr. SENCER. The major activities of the National Institute for Occupational Safety and Health during the past year have been the increased awareness of the presence of occupational carcinogens such as vinyl chloride and asbestos; the development of criteria for toxic materials and harmful physical agents and substances for recommendation of standards to the Department of Labor; the acquisition of safe and improved laboratory space in a permanent facility; and the conducting of industrywide studies to determine the effects of multiple occupational exposure ot toxic materials or harmful physical agents.

Senator MAGNUSON. How many criteria documents are you now producing?

Dr. SENCER. To date, the National Institute for Occupational Safety and Health has completed 30, and revised 1 criteria document. An additional 19 documents are scheduled for completion by July 1, 1976. In future years, 24 documents per year will be scheduled for completion.

Senator MAGNUSON. How is your liaison with the Environmental Protection Agency on problems that have both an environmental and an occupational component?

Dr. SENCER. Dr. Finkle, before becoming National Institute for Occupational Safety and Health Director, was director of the Environmental Protection Agency Health Effects Laboratory in North Carolina. He brought with him a thorough knowledge of the Environmental Protection Agency organization and of individuals within the Environmental Protection Agency. Considerable contacts have been made between the National Institute for Occupational Safety and Health and Environmental Protection Agency over the last 6 months. Furthermore, the National Institute for Occupational Safety and Health has designated an individual to maintain formal liaison with the Environmental Protection Agency in addition to the many informal research programs involved with the relationships between individuals within the National Institute for Occupational Safety and Health and the Environmental Protection Agency.

The health effects of energy technologies in which the National Institute for Occupational Safety and Health is involved has been extensively coordinated with the Environmental Protection Agency. Problems in this area frequently involve both an environmental and occupational health component. The working relationships thus far on that program have been excellent.

The vinyl chloride problem is another example of good National Institute for Occupational Safety and Health and the Environmental Protection Agency liaison. Much of the basis for the Environmental Protection Agency decision regarding vinyl chloride in the general environment was provided from National Institute for Occupational

Safety and Health developed information. Close working relationship were maintained between the National Institute for Occupational Safety and Health and the Environmental Protection Agency in the vinyl chloride situation.

CONTACTS WITH INDUSTRY RESEARCH GROUPS

Senator MAGNUSON. Do you feel that your contacts with industry research groups are improving? What about your contact with employers?

Dr. SENCER. As a matter of policy we have always openly encouraged both labor and management to sit down together with us and discuss areas of mutual interest. Industry alerted us of the liver cancers caused by vinyl chloride. We have by and large been pleased with the cooperation we have received from both groups and feel that is is proving so advantageous to all parties that these mutual exchanges will become more frequent in the future.

Senator MAGNUSON. I understand that a survey was made of American Medical Association physicians who deal with occupational problems to find out what the issues are in the field. What were the results of this survey?

Dr. SENCER. I am unaware of a specific survey conducted of the American Medical Association which dealt with issues in the area of occupational problems. However, I believe they do receive information on the number of physicians who have a primary, secondary, or tertiary interest in occupational medicine but do not ask for substantive information on what physicians consider as occupational medical issues. As I recall, 2,500 physicians listed occupational medicine as their primary specialty, and an additional 5,000 listed occupational medicine as a secondary or tertiary interest.

PRODUCTION COSTS FOR CRITERIA DOCUMENT

Senator MAGNUSON. What is your cost for producing a criteria document? The lowest to the highest?

Dr. SENCER. The National Institute for Occupational Safety and Health financial records system does not provide for maintaining cost on an individual criteria document basis. The average cost in recent years is approximately $240,000 per document.

Senator MAGNUSON. How do you decide which particular substances to produce criteria documents on?

Dr. SENCER. In 1973, the National Institute for Occupational Safety and Health identified some 500 hazardous substances that presented problems to the Nation's work force and ranked them in priority order. Within the last several months the list was reviewed and revised to reflect new information and ranking criteria. In establishing priorities the following 5 criteria are now considered. First, the number of workers exposed; second, the severity of the health effect; third, the carcinogenicity of the substance; fourth, the existence of a present Occupational Safety and Health Administration standard; and fifth, the recommendations of a new or revised threshold limit value. The priority list is not static and will be subject to continual change based on

new information and concepts for determining the magnitude of the problem it presents.

Senator MAGNUSON. What is the major factor which determines how fast a criteria document can be produced?

Dr. SENCER. The major limiting factor in the time required to produce a criteria document is the effort needed to review and assimulate pertinent information and to write the draft document. For the sake of the integrity of a document most of the effort must be by a single criteria document manager who is assigned responsibility for the document.

Senator MAGNUSON. Can the process be speeded up without loss of quality?

Dr. SENCER. To increase the efficiency of the procedure, we are now developing single documents covering multi-hazardous substances. This appears to be feasible where there are certain essential similarities among the substances. While the time to produce a document will not be decreased, the manpower per substance should drop without a loss of quality.

OBTAINING ADEQUATELY TRAINED PERSONNEL

Senator MAGNUSON. Do you find that you have difficulty in obtaining adequately trained personnel in any field?

Dr. SENCER. Yes, particularly in the field of epidemiology, industrial hygiene, and occupational medicine.

Senator MAGNUSON. Are there workers who are exposed occupationally to polychlorinated biphenyls, in the manufacture of transformers and capacitors perhaps?

Dr. SENCER. There are workers who are exposed occupationally to polychlorinated biphenyls in the manufacture of transformers and capacitors and possibly in such other occupational areas as the formulation and use of investment casting waxes, waste disposal activities including the handling and incineration of "carbonless carbon paper," discarded electrical equipment, automobiles, and tires, waste paper reclamation, and polychlorinated biphenyl manufacture.

Senator MAGNUSON. Have you done any investigation of this?

Dr. SENCER. The National Institute for Occupational Safety and Health has conducted walk-through surveys of several capacitor and/or transformer manufacturing plants. The purpose was to detemine the feasibility of using their worker populations to study correlation of mortality experience with workplace exposure levels.

OCCUPATIONAL FACTORS IN HEART ATTACKS

Senator MAGNUSON. Heart attacks are sometimes covered by workman's compensation. Since heart disease is the leading disease killer, what is the National Institute for Occupational Safety and Health doing to investigate those occupational factors that lead to it?

Dr. SENCER. We are conducing several stress research projects which seek to clarify the importance of job stress in the etiology of certain health problems and examine in detail the psychological job stress and health factors specific to policemen and underground coal miners; and

to index the nature, prevalence, and severity of psychological job stress problems for major job types and occupations and their assorted health consequences.

STUDY OF TOXIC SUBSTANCES

Senator MAGNUSON. Some groups of workers are especially sensitive to toxic substances, for instance, pregnant women. What are you doing to emphasize this?

Dr. SENCER. Current occupational safety and health standards as well as past National Institute for Occupational Safety and Health criteria documents have not considered special problems of women in the workplace. This is largely because of the virtual lack of health effects studies at least in the Western literature focusing on women and the unborn child as a high risk group with respect to chemical exposures in the workplace.

In the past, much of the attention relating to protecting the health of women, especially the pregnant woman and the fetus, has centered around nonoccupational hazards, such as drugs, infectious diseases, smoking, et cetera. The National Institute for Occupational Safety and Health has taken the lead in emphasizing the potential hazards to women and the fetus including teratogenic and mutagenic effects associated with occupational exposures and the complex social, legal, and health issues that accompany this problem. Since most carcinogens are also suspected of being mutagens, the magnitude of this potential problem is suspected to be substantial.

The mission of the National Institute for Occupational Safety and Health initiative on women in the workplace over the next 5 years is primarily fourfold:

First, to incorporate into the Institute's ongoing research programs greatly expanded studies of women, and particularly the pregnant woman and the fetus, with a special emphasis on carcinogenesis including transplacental carcinogenesis mutagenesis and teratogenesis;

Second, to incorporate into the Institute's research program studies relating to mutagenic effects of chemicals upon male germ cells;

Third, to include in future criteria documents and update of criteria documents as well as in medical surveillance guidelines to physicians in the standards completion program any information which may implicate an agent as a potential human mutagen, teratogen, or transplacental carcinogen; and

Fourth, to educate workers, management, and the scientific community about this emerging problem including publishing in the List of Toxic Agents, those agents which have been shown to be teratogenic or mutagenic by animal experimentation.

ASBESTOS, KEPONE, AND VINYL CHLORIDE

Senator MAGNUSON. What kind of effort and progress are you making in the area of asbestos, kepone, and vinyl chloride?

Dr. SENCER. We have transmitted criteria for standards to the Occupational Saftey and Health Administration for asbestos and vinyl chloride and, in addition, are conducting additional research in those areas, such as the etiology of asbestos-related cancers and mortality

studies of workers exposed to vinyl chloride. As for the pesticide, kepone, the National Institute for Occupational Safety and Health and other Center for Disease Control officials met with Dr. Robert Jackson, of the Virginia State Health Department, in September, to discuss plans for long-term medical surveillance of kepone workers. In November and December, the National Institute for Occupational Safety and Health developed recommendations for analysis of kepone, and collected information on domestic kepone users and formulators. In January 1976, we transmitted to the Occupational Safety and Health Administration a recommended standard for occupational exposures to kepone.

OCCUPATIONAL SAFETY AND HEALTH TRAINING PROGRAM

Senator MAGNUSON. What is your request for the Occupational Safety and Health training program? Is this lower than the fiscal 1975 or 1976 level?

Dr. SENCER. The 1977 budget request, which provides $1.3 million for manpower development, is lower as compared to $3.2 million and $4.2 million for fiscal years 1975 and 1976 respectively.

Senator MAGNUSON. Why are you phasing down this program? Isn't it a very important area?

Dr. SENCER. The decrease in 1977 reflects elimination of the training grant program at the end of fiscal year 1976. The original intent of this grant program was to stimulate the development of curricula and training programs in the occupational safety and health areas. We feel that many of these curricula will continue as a result of the supply and demand system. We are, in addition, continuing to work with other manpower programs throughout the Department.

Senator MAGNUSON. What kind of coordination of programs do you have with the Department of Labor, and what can you do to improve this relationship with your Occupational Safety and Health program?

Dr. SENCER. The National Institute for Occupational Safety and Health and the Occupational Safety and Health Administration are currently holding regular monthly meetings. In addition, the National Institute for Occupational Safety and Health Safety Task Force, which was established to develop a National Occupational Safety program plan, has two Occupational Safety and Health Administration staff on it.

CENTER FOR DISEASE CONTROL RESCISSION

Senator MAGNUSON. Please explain to me why it is a good time to take funds, at least partially, away from 50 of the 64 operating rat control projects.

Dr. SENCER. Grants for rat control were intended to serve as "seed" money. Grantees committed themselves to increasing local support as Federal funds were reduced. Our budget reflects this concept. We assume this local support will be forthcoming, and also we are assisting grantees in identifying other sources of financial support.

Senator MAGNUSON. What would this proposed reduction do to the rat population?

Dr. SENCER. We are hopeful that communities which have established effective programs will maintain them as Federal support is reduced or eliminated. The extent to which this happens, and additional communities initiate programs similar to the ones started with project grant funds, will depend upon the priority which local and State governments place on rat control.

Senator MAGNUSON. Can you tell me the population as it pertains to people of the areas presently served by the rat control programs?

Dr. SENCER. Approximately 6 million people are directly receiving the benefits of rat control activities in the 64 program communities presently receiving grant support. Programs are operating in 30 States.

Senator MAGNUSON. Tell us exactly how the State and local governments would pick up the costs of this program, as well as what you have done to prepare them for this.

Dr. SENCER. Local support of project activities has been required from the outset of the program, and the grantee share of federally assisted projects has increased from 27 percent in fiscal year 1969 to 57 percent in fiscal year 1975. Approximately $1 million was made available to rat control projects in 1975 through the Commerce Department's job opportunities program. In addition, we are encouraging local health departments to request funds for rat control activities under "Housing and urban development," community development block grants and through Comprehensive Employment and Training Act programs.

JUSTIFICATION

Senator MAGNUSON. Thank you, Dr. Sencer. Your budget justification material will be placed in the record at this point.

[The justification follows:]

Justification

Appropriation Estimate

Preventive Health Services

To carry out, to the extent not otherwise provided, title III of the Public Health Service Act, *the Lead-Based Paint Poisoning Prevention Act*, 1/ the Federal Coal Mine Health and Safety Act of 1969, and the Occupational Safety and Health Act of 1970; including insurance of official motor vehicles in foreign countries; and purchase, hire, maintenance, and operation of aircraft; [$108,971,000] *$143,293,000:* Provided, That training of employees of Federal, State, and local governments and of private agencies, shall be made subject to reimbursement or advances to this appropriation for the full cost of such training.

[For an additional amount for "Preventive Health Services" for carrying out, to the extent not otherwise provided, section 317 of the Public Health Service Act with regard to Rat Control project grants, $13,100,000.] 2/

1/ Not in conference report because of lack of authorization in 1976.

2/ Language for Supplemental Appropriation Act, 1976, deleted.

Preventive Health Services

Amounts Available for Obligation 1/

	1976	1977
Appropriation	$122,071,000	$143,293,000
Pending request: Disease Control project grants authorized under continuing resolution	28,300,000	---
Comparative transfers to: "Salaries and Expenses", Department of State for shared administrative support of overseas posts	-18,000	---
Subtotal, budget authority	150,353,000	143,293,000
Unobligated balance, start of year	3,156,000	---
Unobligated balance, end of year	---	---
Total, obligations	153,509,000	143,293,000

1/ Excludes the following amounts for reimbursable activities carried out by this account: 1976 - $10,000,000; 1977 - $10,000,000.

Summary of Changes

1976 Estimated Obligations	$153,509,000
1977 Estimated Obligations	143,293,000
Net Change	-10,216,000

	1976 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Increases:				
A. Built-in:				
1. Annualization of positions new in 1976	---	$1,272,000	---	+$139,000
2. Annualization of pay raises	---	3,216,000	---	+925,000
3. Within-grade pay increases	---	---	---	+1,170,000
4. Payment to GSA for rent	---	4,121,000	---	+393,000
5. HEW working Capital fund	---	378,000	---	+23,000
6. PHS service and supply fund	---	188,000	---	+67,000
7. Office of Federal Employees Health Benefits increase	---	422,000	---	+34,000
8. FTS, postage, and utility rate increases	---	2,171,000	---	+557,000
Subtotal			---	+3,308,000
B. Program:				
1. Laboratory improvement - to integrate the CLIA and Medicare laboratory certification process	509	10,601,000	+49	+4,034,000
Subtotal			+49	+4,034,000
Total, increases			+49	+7,342,000
Decreases:				
A. Built-in:				
1. One less day of pay	---	222,000	---	-222,000
Subtotal				-222,000
B. Program:				
1. Disease control - Project grants - reduced level of Federal support	413	41,400,000	-150	-7,690,000

Summary of Changes -- continued

	1976 Base		Change from Base	
	Pos.	Amount	Pos.	Amount
Decreases - continued				
B. Program - continued				
2. Disease control - Disease investigations, surveillance, and control - for reduced surveillance and TB research	1,509	43,411,000	---	-1,503,000
3. Health education - reduction in Smoking and Health and project evaluation	36	3,513,000	---	-531,000
4. Occupational health - Grants - elimination of Training grant program	---	4,900,000	---	-3,000,000
5. Occupational health - Direct operations	773	34,633,000	-2	---
6. Buildings and facilities - Completion of planning phase for Occupational health facility	---	4,612,000	---	-4,612,000
Subtotal			-152	-17,336,000
Total, decreases			-152	-17,558,000
Total, net change			-103	-10,216,000

Crosswalk to Obligations by Activity

Increases:

A. Built-in:

The increase of $3,308,000 includes $1,589,000 for Disease control - Disease investigations, surveillance, and control; $457,000 for Disease control - Laboratory improvement; $33,000 for Disease control - Health education; $649,000 for Occupational health - Direct operations; and $580,000 for Program management.

Decreases:

A. Built-in:

The decrease of $222,000 includes $86,000 for Disease control - Disease investigations, surveillance, and control; $29,000 for Disease control - Laboratory improvement; $2,000 Disease control - Health education; $75,000 for Occupational health - Direct operations, and $30,000 for Program management.

Obligations by Activity

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Disease control:								
(a) Project grants	563	33,710,000	563	41,400,000	413	33,710,000	-150	-7,690,000
(b) Disease investigations, surveillance, and control.	1509	43,411,000	1509	43,411,000	1509	43,411,000	---	---
(c) Laboratory improvment.	469	9,989,000	509	10,601,000	558	15,063,000	+49	+4,462,000
(d) Health education.	36	3,013,000	36	3,513,000	36	3,013,000	---	-500,000
Occupational Health:								
(a) Grants.	---	1,900,000	---	4,900,000	---	1,900,000	---	-3,000,000
(b) Direct operations.	673	30,281,000	773	34,633,000	771	35,207,000	-2	+574,000
Buildings & facilities	---	3,156,000	---	4,612,000	---	---	---	-4,612,000
Program management.....	264	10,989,000	264	10,439,000	264	10,989,000	---	+550,000
Total obligations	3514	136,449,000	3654	153,509,000	3551	143,293,000	-103	-10,216,000

Obligations by Object

	1976 Estimate	1977 Estimate	Increase or Decrease
Total number of permanent positions	3,654	3,551	-103
Full-time equivalent of all other positions	250	250	---
Average number of all employees	3,591	3,494	-97
Personnel compensation:			
Permanent positions	$57,191,000	$58,400,000	+$1,209,000
Positions other than permanent	1,803,000	1,803,000	---
Other personnel compensation	1,272,000	1,272,000	---
Subtotal, personnel compensation	60,266,000	61,475,000	+1,209,000
Personnel benefits	8,178,000	8,304,000	+126,000
Travel and transportation of persons	3,114,000	3,164,000	+50,000
Transportation of things	742,000	770,000	+28,000
Rent, communications and utilities	7,687,000	8,394,000	+707,000
Printing and reproduction	969,000	1,005,000	+36,000
Other services	9,597,000	6,904,000	-2,693,000
Project contracts	18,182,000	18,748,000	+566,000
Supplies and materials	3,662,000	3,927,000	+265,000
Equipment	2,213,000	2,393,000	+180,000
Grants, subsidies and contributions	38,901,000	28,211,000	-10,690,000
Subtotal	153,511,000	143,295,000	-10,216,000
Less quarters and subsistence	-2,000	-2,000	---
Total obligations by object	153,509,000	143,293,000	-10,216,000

Significant Items in House and Senate Appropriations Committee Reports

Item	Action taken or to be taken
1976 House Report	
Buildings and Facilities	
The Committee provided $1,100,000 for buildings and facilities to plan a modern and safe facility at a suitable location for the Research Activities of NIOSH presently located in Cincinnati, Ohio. The Committee expects a full report from HEW by 1/1/76 on the various cities considered for location of the facility, the basis for final site selection, the size and cost of the building and plans for improving working conditions at Cincinnati until the new facility is constructed.	The Senate added an additional $356,000 to complete plans for the NIOSH facility. The appropriation was vetoed by the President. Funds for this project are not available under the continuing resolution. A full report has been submitted to Congress.
Lead-Based Paint Poisoning Program	
The Committee expressed its disappointment with CDC's efforts in assisting the other service and Health Financing Programs of HEW to incorporate routine lead screening as an integral part of the delivery of health care. The Committee directed CDC and the Assistant Secretary for Health to redouble their efforts to encourage other health components of HEW to perform routine screening of their patients to detect lead poisoning and expects a full report at the time of the Lead-Based Paint Poisoning Hearings.	The Department continues to emphasize lead screening through several Federal Agencies and non-federal counterparts by developing lead screening guidelines for the early screening, diagnosis, and treatment (EPSDT) programs; through coordination of the Childhood Lead Poisoning Prevention Program (CLPP) and EPSDT; and through liaison between EPSDT and CLPP at the State and local levels. For EPSDT Programs, 17 States now require a screening test for undue lead absorption and 32 of the remaining 33 States provide a reimbursement procedure for lead poisoning screening. CDC has developed or enhanced the lead analysis capability in 28 State laboratories and along with 75 other laboratories, insures their continuing excellence with a Proficiency Testing Program.
1976 Senate Report	
Health Education	
The Committee directed that an additional $1 million added to the House allowance and budget request be utilized primarily for preventive medicine and that a report be submitted describing what the Center has developed and what progress has been made in the area of Health Education Programs.	Five hundred thousand was allowed by the Conference Committee. The President vetoed the appropriation. Funds are not available under the continuing resolution. The directed report is being prepared.

Authorizing Legislation

	Amount Authorized	1977 Budget Request
Preventive Health Services Activity:		
1. Disease control		
a. Project grants		
Section 317(d) (2) and (3) of the Public Health Service Act.		
Section 318(d) (2) of the Public Health Service Act.	1/	$4,960,000
Lead-Based Paint Poisoning Prevention Act of 1973.	1/	19,840,000
Section 317(d) (3) of the Public Health Service Act.	1/	3,500,000
	2/	5,410,000
b. Disease investigations, surveillance, and control		
Sections 301, 308, 311, 315, 322(e), 325, 327, 328, 352, 353, and 361 thru 369 of the Public Health Service Act.	Indefinite	43,411,000
c. Laboratory improvement		
Sections 301, 311, 327, 328, 352, and 353 of the Public Health Service Act.	Indefinite	15,063,000
d. Health education		
Sections 301, 311, and 315 of the Public Health Service Act.	Indefinite	3,013,000
2. Occupational health		
a. Grants		
Sections 301 and 311 of the Public Health Service Act.	Indefinite	1,900,000
b. Direct operations		
Sections 301, 311, 327, and 328 of the Public Health Service Act; the Federal Coal Mine Health and Safety Act of 1969; and the Occupational Safety and Health Act of 1970.	Indefinite	35,207,000
3. Program management		
Sections 301, 308, 311, 314(e), 315, 317, 318, 322(e), 325, 327, and 328 of the Public Health Service Act; the Lead-Based Paint Poisoning Prevention Act of 1973; the Federal Coal Mine Health and Safety Act of 1969; and the Occupational Safety and Health Act of 1970.	Indefinite	10,989,000
Total 1977		143,293,000

1/ Section 317(d)(2) and (3) and Section 318(d)(2) of the Public Health Service Act and the Lead-Based Paint Poisoning Prevention Act of 1973 expired June 30, 1975 - extension of legislation has been proposed.

2/ Section 317(d)(3) of the Public Health Service Act expires June 30, 1976 - extension of legislation has been proposed.

Preventive Health Services

	Budget Estimate to Congress	House Allowance	Senate Allowance	Appropriation
1967	44,230,000	44,220,000	44,220,000	44,220,000
1968	72,272,000	72,109,000	72,109,000	72,109,000
1969	63,407,000	62,144,000	62,144,000	62,144,000
1970	79,331,000	79,238,000	79,238,000	79,238,000
1971	82,138,000	82,538,000	90,600,000	84,538,000
1972	138,996,000	138,996,000	157,911,000	143,303,000
1973	139,980,000	159,972,000	223,970,000	159,970,000
1974	128,869,000	130,869,000	152,569,000	141,547,000
1975 considered	124,714,000	134,910,000	140,443,000	152,345,000
1976	96,601,000	107,115,000	112,471,000	122,053,000
Supplemental	5,410,000	10,410,000	13,710,000	13,100,000
Pending	28,300,000			
1977	143,293,000			

Justification

Preventive Health Services

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Disease Control:								
(a) Project grants..	563	$33,710,000	563	$41,400,000	413	$33,710,000	-150	-$7,690,000
(b) Disease investigations, surveillance, and control.	1509	43,411,000	1509	43,411,000	1509	43,411,000	---	---
(c) Laboratory improvement....	469	9,989,000	509	10,601,000	558	15,063,000	+49	+4,462,000
(d) Health education	36	3,013,000	36	3,513,000	36	3,013,000	---	-500,000
Occupational health:								
(a) Grants...	---	1,900,000	---	4,900,000	---	1,900,000	---	-3,000,000
(b) Direct operations...	673	30,281,000	773	34,633,000	771	35,207,000	-2	+574,000
Buildings and facilities...	---	3,156,000	---	4,612,000	---	---	---	-4,612,000
Program management...	264	10,989,000	264	10,439,000	264	10,989,000	---	+550,000
Total obligations..	3514	136,449,000	3654	153,509,000	3551	143,293,000	-103	-10,216,000

General Statement

The Preventive Health Services appropriation provides support for the Center for Disease Control, an agency of the Public Health Service which is the center of competence in the prevention and control of infectious diseases and certain other conditions. CDC's mission is to assist State and local health authorities and other health related organizations in stemming the spread of communicable diseases, in providing protection from certain environmental hazards, and improving occupational safety and health. This mission is carried out through a multiphasic program which includes: (1) research, investigation, and evaluation of new methods of disease control or provention; (2) provision of epidemic aid; (3) technical consultation and assistance in all aspects of communicable disease control; (4) active surveillance of disease and reporting on trends and developments; (5) laboratory improvement; (6) direction of a national health education program; and (7) occupational safety and health. In addition, CDC is responsible for certain national health functions including the licensure of clinical laboratories engaged in interstate commerce and foreign quarantine activities aimed at preventing the introduction of disease into our Nation.

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Disease control:								
Project grants								
Venereal disease....	473	$19,840,000	473	$19,840,000	348	$19,840,000	-125	---
Immunization	80	4,960,000	80	4,960,000	58	4,960,000	-22	---
Rat control	10	5,410,000	10	13,100,000	7	5,410,000	-3	-$7,690,000
Lead-Based paint poisoning in children	---	3,500,000	---	3,500,000	---	3,500,000	---	---
Disease investigations, surveillance, and control.....	1509	43,411,000	1509	43,411,000	1509	43,411,000	---	---
Laboratory improvement.	469	9,989,000	509	10,601,000	558	15,063,000	+49	+4,462,000
Health education...	36	3,013,000	36	3,513,000	36	3,013,000	---	-500,000
Total.....	2577	90,123,000	2617	98,925,000	2516	95,197,000	-101	-3,728,000

Project grants

These project grant activities would be consolidated in the State bloc grant program prepared for later transmittal.

Venereal Diseases

The incidence of syphilis and gonorrhea remain at unacceptably high levels, but favorable changes in disease patterns and control program activities are being witnessed in 1976 and should continue in 1977. Major emphasis continues to be placed on control programs for these two diseases because they are highly communicable and cause major disability if not treated early in the infection, and control methodologies are available. Because the population is extremely mobile and high rate of inter- and intrastate disease transmission occurs, and because intervention activities often require cooperative follow-up by two or more States, control efforts must be carried out uniformly on a national basis.

Project grant funds are awarded to official health agencies principally to support disease intervention activities at the State and local level. The primary objectives of these programs are (1) screening high risk female populations for gonorrhea; (2) surveillance of syphilis through serologic screening of specific population segments; (3) providing contact referral services to patients with infectious syphilis and gonorrhea; (4) providing venereal disease facts to people at risk to prevent exposure to venereal disease and to influence infected individuals to seek early medical care; and (5) involving the private medical community in all aspects of venereal disease control. During 1977, screening programs for gonorrhea will become more focused as nonproductive screening efforts are discontinued and as post-treatment and periodic rescreening of both male and female gonorrhea patients is implemented. Greater emphasis will be placed on simultaneous treatment of steady sex partners, particularly through greater involvement of patients in referring their sex partners to medical care. Each of these gonorrhea program efforts reduces both the cost of contact follow-up and the likelihood of immediate exposure of the patient to reinfection. Syphilis epidemiologic case management efforts will be strengthened to maximize the impact of contact referral and epidemiologic treatment on case prevention, and to

continue to gear health department policies and control program activities to specific high risk groups, particularly the gay community, which has emerged as a group for which specially tailored control programs have proved very effective.

Educational efforts during 1977 will focus on providing information about venereal disease to persons at high risk of acquiring infection, specifically to the person with a history of repeat infections, in an attempt to reduce further reinfection and transmission of disease. Physicians will be encouraged to simultaneously treat sex partners and involve patients in the referral of their sex partners to medical care.

During 1977, we will also continue to generate increased support of venereal disease control programs by State and local governments and other Federal sources. Some of the cuts in Federal project grants in 1976 were offset by supplemental funding of $1.6 million in seven project areas through the Job Opportunities Program of the Public Works and Economic Development Act (Title X).

The trends in recently acquired syphilis continue to be mixed as indicated below:

	1974	1975	Percent Change
Primary and Secondary (total)	24,728	25,746	+4.1
Males	17,079	18,415	+7.8
Females	7,649	7,331	-4.2
Early Latent (total)	24,290	26,166	+7.7

The national increase in syphilis has resulted from large increases in a few areas of the country, and as indicated above, has largely been limited to males. However, early 1976 data show a decline in primary and secondary syphilis.

Although the annual percentage increase in the incidence of gonorrhea has slowed from 12.7 percent in 1973, to 8.0 percent in 1974, to 7.4 percent in 1975, gonorrhea continues to rank first among all reportable diseases. It continues to be reported most frequently from the 63 large cities with populations of 200,000 or more. These cities, comprising 28 percent of the Nation's population, accounted for 53.4 percent of the reported cases during 1975. However, 23 of these cities reported a decrease in gonorrhea in 1975, and the overall increase in gonorrhea in the 63 cities was 4.2 percent compared to 11.3 percent for the rest of the nation.

In screening programs for gonorrhea during 1975, 8,863,899 culture specimens were obtained from women. Of those cultured, 375,863 (4.2%) were positive for gonorrhea, and treatment was documented for 92 percent of the women with positive results. Because of gonorrhea screening and other outreach efforts, infected women are being treated earlier in their infection and removed from the infectious reservoir thereby preventing further spread of the disease and development of the serious complications of gonorrhea. The fact that positivity rates from screening programs have remained relatively stable at 4.2 percent suggests that the incidence of gonorrhea among females may, in fact, be stabilizing.

Immunization

During 1977, grants will continue to be provided to assist States and localities in carrying out immunization programs, although Federal contributions to each program will be reduced. States and localities will be expected to support an increased share of routine vaccine costs and delivery systems from non-project grant resources. We anticipate using project grant funds to put special

emphasis on developing the capability of States in rapidly identifying and containing outbreaks of disease. These activities will be based on the experience of several pilot areas in the north central part of the country which are now carrying out intensive measles containment programs. In addition, grantees will be encouraged to refine overall assessment activities in order to pinpoint pockets of high disease susceptibility before outbreaks of disease occur, and to carry out targeted immunization programs to improve the level of protection against vaccine preventable diseases among pre-school children in these groups.

During calendar year 1974, most childhood vaccine preventable diseases continued to decline with measles, rubella, and polio reaching all time lows since national statistics have been collected. According to the 1974 Immunization Survey, the level of protection against all of these diseases had increased slightly in all age groups compared to 1973, with approximately 60 percent of all pre-school children protected by vaccine against rubella, 63 percent against polio, 65 percent against measles, and 74 percent against diphtheria, tetanus, and whooping cough. However, there is known to be considerable variation in protection levels among various population subgroups, with vaccine protection being particularly low among the urban and rural poor. This disparity continues, although the 1974 survey suggests that the gap has been narrowed slightly.

Morbidity reports for the first eleven months of calendar year 1975, however, show that both measles and rubella are increasing once again. Rubella morbidity was up 38.7 percent over the same period a year ago, and measles morbidity was up 7.9 percent. It is anticipated that the measles containment programs being implemented on a pilot basis will prove effective in substantially curtailing the spread of disease among susceptible children. The key elements of this strategy, which are similar to those employed in the worldwide smallpox eradication program, are a sensitive surveillance system which identifies outbreaks of disease early, and a rapid response capability to vaccinate susceptible children who are at immediate risk of exposure. Both measles and rubella vaccinations are provided. This approach permits health departments to target their resources on interrupting transmission of measles and rubella, and at the same time it facilitates the identification of pockets of high disease susceptibility. Operating in conjunction with ongoing immunization programs, including mass public and professional awareness campaigns, it is anticipated that both measles and rubella morbidity can be substantially reduced.

Rat Control

Since 1969, project grants have been awarded to urban areas to reduce rat infestations and to insure the maintenance of rat control programs by local and State governments and through voluntary community action. During 1976, these grants are being provided for the first time under the disease control authority of section 317 of the Public Health Service Act, which should simplify their administration and give recognition to the similarities between rat control and disease control programs in terms of operational strategies and target populations. The existing technology for reducing rat infestations has been successfully demonstrated, and local areas and States are demonstrating the capability to participate fully in maintaining control once it has been established.

During 1977, priority will be given to providing continuation funding to projects in communities with the most severe rat problems and those which are developing sound control programs and have substantial State or local financial support. The Federal share of each of these projects will be reduced. States and local communities will be expected to increase their contribution to insure that no regression occurs in rat control activities. It is anticipated that this level of funding will support approximately 50 community programs through 30 to 35 project grants.

At the present time, 64 program communities supported through 39 project grants are currently serving 6,000,000 people. Most of these activities are being supported through grants made late in 1975. By the end of 1976, it is expected that 21,000 of the total 40,157 target blocks will reduce rat infestations and the conditions conducive to such infestations to a point where routine maintenance operations will be sufficient to sustain the progress that has been made. Additional progress is expected in reducing rat problems in some 10,581 blocks which are in the intensive rat reduction phase of the program.

With 1976 funds, we anticipate providing continued support to 60 of these community programs, with responsibility for maintenance activities in many existing blocks being turned over completely to State and local governments for support. This funding will pave the way for full termination of Federal support to approximately 10 of these communities in 1977, and for reduced Federal support to most of the remaining community programs. Program regression during 1976 and 1977 is to be prevented by increased State and local contributions to these programs, and through the use of other sources of Federal assistance. During 1976, approximately $1,000,000 was provided as supplementary funds to seven urban rat control grantee communities under the Job Opportunities Program of the Public Works and Economic Development Act (Title X).

Lead-Based Paint Poisoning in Children

Project grants for the control of lead-based paint poisoning in children are made to assist communities in developing child screening and follow-up programs. These grants are used primarily to develop an active lead-based paint poisoning prevention program which can coordinate lead screening and follow-up activities of other child health programs, and supplement these activities by providing an active outreach effort in neighborhoods where lead-based paint is accessible to children. The abatement of environmental lead hazards in residential dwellings of affected children is required, although costs for these actions generally are not supported by project grant funds.

Funds available in 1977 will be awarded only to those programs which continue to document a significant problem and which have developed productive programs. The number of projects funded is expected to remain at approximately 30 to 35. It is estimated that 250,000 children will be screened in these projects, and 20,000 will be found with undue lead absorption. Additional children will continue to be screened by Early and Periodic Screening, Diagnosis and Treatment (EPSDT) programs under Medicaid, and Maternal and Child Health (MCH) programs of the Public Health Service.

For the fiscal year ending on June 30, 1976, 71 project communities will screen an estimated 525,000 children for undue lead absorption, utilizing project grant funds awarded late in 1975. It is estimated that 34,200 children will be placed under pediatric management for undue lead absorption with approximately 4,400 children requiring chelation therapy. Appropriate lead abatement action will be carried out in 75 percent of those houses found with a lead hazard.

The 1976 appropriations will be used to continue support to approximately 35 of these projects which are faced with the most severe lead poisoning problem, and which have developed effective programs. With increased State and local support, and with full implementation of a newly developed and much cheaper screening procedure, 1976 funds will enable these programs to screen approximately 250,000 children during 1977, and to identify 25,000 children with undue lead absorption. It is assumed that in those communities not receiving project funds where a significant lead-based paint poisoning problem exists, States and localities will continue the necessary activities with their own resources. Additionally, there are other Federal funds which can be used to carry out some of the program elements where local officials determine it necessary. These include the EPSDT program; the Job Opportunities program (Title X of the Public

Works and Economic Development Act); the Comprehensive Employment and Training Act (CETA); MCH programs; and Title I of the Housing and Community Development Act of 1974. Some funds from these programs will also be used to augment the activities of the funded projects. It is estimated that in addition to the 250,000 children screened by the funded projects, 300,000 children will be screened by EPSDT and MCH programs during 1976.

Disease investigations, surveillance, and control

This budget activity supports a wide variety of public health functions aimed at control of a multitude of diseases and conditions, and represents the major aspect of the preventive health activities. The scientific and technical competence and facilities which are devoted to this work represent a valuable national health resource.

Surveillance

The Center for Disease Control maintains surveillance over diseases of public health significance occurring in this country or presenting a threat of introduction from other nations. Surveillance reports for 30 diseases were issued in 1975 with an approximate average circulation of 5,000 for each report.

The main component of the Center's surveillance program is the Epidemic Intelligence Service (EIS). In addition to headquarters staff, EIS officers are located in 42 State and city health departments throughout the United States. Approximately 1,500 separate disease outbreaks will be investigated during 1976 in collaboration with local health workers, and an estimated 1,500 such investigations will be conducted during 1977.

In 1976, the Center processed 140,000 of the most difficult reference diagnostic specimens from throughout the Nation. Approximately 1.8 million different determinations were made on these specimens. For 1977, a modest growth is expected in this area.

Nosocomial infections - Infections developed during hospitalization constitute a serious public health problem. Based on limited data, it is broadly estimated that hospital infections add seven days to the average hospital stay, increasing the cost of health care in this country by more than $1 billion.

To gain better knowledge of the nature and scope of the problem, CDC conducts a continuous surveillance program, called the National Nosocomial Infections Study (NNIS), involving 80 hospitals. Infection control personnel make telephonic surveillance reports daily to CDC. This data is used to evaluate infection control efforts and as a basis for investigating important public health problems.

In addition, CDC is undertaking a major retrospective study designed to accurately determine not only current prevalence of hospital infections, but also the effectiveness of infection control in terms of improved patient health, reduced hospital stay, and lowered health costs. The Study of the Efficacy of Nosocomial Infection Control (SENIC) is a study which can serve as a basis for hospital infection control decisions for many years into the future.

Influenza - Nationwide influenza surveillance from various reporting levels encompassing 400 institutions in 138 cities was continued and expanded upon in 1976.

With the recognition of a new strain of influenza virus A/Victoria strain in several Western Pacific countries this past fall, intensified influenza surveillance efforts were mounted. Influenza-like illness was monitored among travelers and computerized summaries of State influenza morbidity and mortality data were regularly provided to each State health department during the influenza season.

Hepatitis - Nationwide surveillance of viral hepatitis will continue in 1977 with expansion of efforts in certain hospital and community settings. Epidemiological factors, such as hospitalization, prior surgery, and dental manipulation, will be studied to pin-point changes in occurrence of hepatitis B and to assess more accurately the factors related to hepatitis B transmission. Efforts to identify hepatitis A cases related to day care centers will be intensified in hopes of controlling possible epidemics within the day care center. Nationwide surveillance of viral hepatitis will focus upon identification of high risk groups in need of hepatitis B immune globulin for prevention of hepatitis B.

Birth defects - Surveillance and epidemiologic studies of birth defects continued in 1975-1976 using data compiled from locally-based surveillance programs. In addition, the nationwide Birth Defects Monitoring Program provides data on approximately one million births a year which are used in examining more national patterns. From these activities, the Center will be able to monitor the occurrence of defects and undertake descriptive and analytic studies of particular birth defects.

Smallpox - Surveillance of suspected smallpox cases has become increasingly more important with the change in vaccination policies and the continuing success of the Smallpox Eradication Program. The geographic area affected by endemic smallpox steadily declined in 1975 as it has been doing since the worldwide Smallpox Eradication Program began in 1967. The Center for Disease Control continued to furnish on-site technical advisors during 1975 for both long and short-term assignments to smallpox endemic areas. Currently, the smallpox endemic area appears limited to Ethiopia where accelerated efforts are underway with considerable WHO financial and technical input. Expectations are that Ethiopia will be free of smallpox during 1976, and the original target of "a smallpox-free world in 10 years," established by the World Health Organization in 1966 will be achieved. This will be the first time in history that man has succeeded in eradicating any disease. The tactics used to achieve this were substantially developed and perfected by the Center for Disease Control in West Africa and extended by CDC personnel to other smallpox endemic areas. During 1976, CDC also furnished technical advisors through WHO to assist in assessment activities to confirm geographically smallpox-free areas. This support will continue in 1977.

Investigations

The Center for Disease Control conducts clinical and epidemiological investigations of selected diseases of public health significance which are carried out both in the laboratory and in the field on infectious and certain noninfectious diseases and conditions.

Viral diseases - During 1976, epidemiologic assistance was provided to various State health agencies during the largest and most geographically widespread outbreak of St. Louis encephalitis (SLE) ever recorded. Epidemic assistance was also provided to North Dakota and Minnesota during an outbreak of western equine encephalitis (WEE).

Laboratory technology has been advanced to the state where it is now possible to recover, repeatedly, the hepatitis A virus (HAV) from chimpanzee and human cases of disease using biophysical techniques. As a result, a new serologic test using an antibody to HAV, has been developed and is being evaluated. In 1977, this test will be refined to the point where large scale national prevalence studies can be initiated to identify populations at high risk.

In 1976, rapid techniques for detection of virus and antibodies were developed for the highly pathogenic Marburg and Lassa fever viruses. Worldwide diagnostic service for these and similar viruses continues to be provided. The expanded maximum security laboratory at CDC, when completed, will provide the specialized facilities needed for laboratory activities involving highly infectious diseases. Work continues on basic immunologic problems as a basis for developing vaccines for hazardous viruses.

Bacterial diseases - During 1975 and 1976, many significant bacterial disease epidemics were investigated by the CDC. Examples of such investigations are: (a) outbreaks of intestinal illness aboard passenger cruise ships; (b) a commercially canned beef-stew product that caused an outbreak of botulism, and (c) one of the largest outbreaks of salmonellosis ever recorded, was caused by faulty food handling practices and improper storage of food.

Streptococcal diseases continue to persist as major public health concerns. Rheumatic heart disease following streptococcal infections affects some 100,000 Americans annually, with an estimated mortality of about 16,000. Research has yielded a test which will add materially to knowledge of better control measures against rheumatic heart disease.

Of equal importance is illness or death of newborns and infants up to 2 years of age who suffer from disease caused by group B streptococci. During 1976, investigations resulted in the development and perfection of a technique to serologically type group B streptococci. During 1977, research will be conducted to develop a reliable and practical laboratory procedure to measure the level of protective antibodies to the group B virulence factors.

A third streptococcal disease of public health importance causes dental caries. During 1976, in collaboration with the National Institute of Dental Research, procedures were developed for the production of diagnostic reagents which will identify plaque-producing streptococci by direct microscopic examination of plaque material obtained from patients with dental caries.

Parasitic diseases - The Center continues to operate a diagnostic serology program for the diagnosis of 23 parasitic infections. During 1976, a new technique was evaluated for the diagnosis of toxoplasmosis. Tests are being evaluated for the detection of organisms in tissues and cerebrospinal fluid which are the cause of serious eye lesions and infections which usually result in death. Collaborative studies on the standardization of diagnostic test reagents for malaria and toxoplasmosis were initiated. During 1977, the standardization of reagents will be emphasized.

Field investigations of several parasitic diseases and a survey of intestinal parasites in Vietnamese refugees were carried out in 1975 and 1976.

Fungal diseases - Fungal diseases constitute important public health problems and in recent years there has been a phenomenal increase in diseases caused by fungi. Deaths directly attributed to pathogenic fungi have averaged 300 per year over the past decade.

To aid the many hospitals and health departments that lack competency, the Center provides a national diagnostic service for fungal diseases. To enable physicians to select the proper chemotherapeutic agents and dosages, the Center initiated a service during 1975 designed to test the sensitivity of fungal isolates to various antifungal drugs.

In 1977, studies will continue on the development of serodiagnostic procedures and the evaluation of a diagnostic blood test will be completed for mycotic diseases being recognized with increasing frequency, for which serologic tests are urgently needed.

Noninfectious diseases - Investigative activity in the area of cancer during 1976 has concerned both viral tumor causation and environmental hazards. Work has continued on analytic studies concerned with (a) the concept that leukemia/lymphoma may be spread from person-to-person, and (b) the combined laboratory/epidemiologic search for antibody against feline leukemia virus among persons exposed to cats shedding such viruses. Studies relating to vinyl chloride exposure have continued concerning patterns of lung cancer among vinyl chloride workers and follow-up of angiosarcoma of the liver cases throughout the U.S..

Projected studies for 1977 will involve continuation of the various studies outlined above; in particular, those related to lung cancer, lead, and feline leukemia virus.

Control

The Center is concerned with carrying out Federal responsibilities for preventing the interstate spread of disease as well as preventing the importation of disease from abroad. Additionally, CDC provides assistance to States and communities in the conduct of their public health programs. Activities include operational research, development of control strategies, and technical assistance, as well as minimal regulatory operations at ports of entry.

Venereal disease - Major efforts during 1976 were directed toward strengthening syphilis control methodologies, refining gonorrhea control strategies and techniques, and developing initiatives for the study of other sexually transmitted diseases. Technical assistance was devoted to reviewing progress in methods of control and new strategies and in developing awareness and surveillance activities for the increasing problem of sexually transmitted diseases (STD's) other than syphilis and gonorrhea.

These efforts will continue in 1977. Emphasis will be placed on (a) developing alternative VD casefinding approaches among male homosexuals; (b) national monitoring to study increasing resistance of GC strains to antibiotics; (c) shifting to posttreatment and rescreening of GC patients; (d) renewed research efforts to define additional risk factors, diagnostic techniques, and treatment for pelvic inflammatory disease (PID); and (e) development of control measures for other sexually transmitted diseases (STD).

Tuberculosis - The reported tuberculosis incidence in the United States for calendar year 1974 was 30,122 cases, a reduction of 2.8 percent from calendar year 1973. Preliminary figures for calendar year 1975 show an anticipated increase in reported tuberculosis morbidity, partly accounted for by a change in reporting requirements as of January 1. Because of this reporting change, 1975 figures are not strictly comparable with those of previous years. However, there may be a leveling off of the average 5 percent annual decline in reported new cases of tuberculosis which was observed during the late 1960's and early 1970's. A major activity for 1976 and 1977 is to provide an indepth analysis of areas showing increases in reported tuberculosis morbidity to determine causes of the increases and to assess what changes in control program activities might account for the increases or might be indicated to combat the increases.

During 1977, the Center will continue its efforts to assist health care providers to realign programs and reallocate resources so that a more effective tuberculosis control program can be accomplished. Also, efforts will be aimed at improving laboratory surveillance and developing pharmacy surveillance in hospitals and clinics. Operational research activities during 1977 will continue the effort to develop methods of quicker and more precise diagnosis of tuberculosis and to assess shorter and more effective regimes for preventive treatment of tuberculous infection and treatment of tuberculosis.

Immunization - This past fall, for the third consecutive year, an intensive motivational and educational campaign called Immunization Action Month (IAM) was coordinated by the Center in an attempt to reduce declining trends in immunization levels. Data from the 1974 United States Immunization Survey reveal a small increase in the 1-4 and 5-9 year age groups who are immune to all of the common vaccine preventable diseases which indicates success of earlier campaigns. Data from the 1975 survey are not yet available. A similar campaign will be conducted in 1977.

Several pilot programs were initiated in 1976 to assess the results of the implementation of an intensive measles containment program similar to the approach used in the smallpox eradication program. During 1977, the Center will continue to refine immunization control strategies.

Environmental Health - The Center also has an active technical assistance program in the broad area of environmental health. Priority is being given to work with State health agencies in an effort to re-establish a strong environmental health technical capability within these organizations. During 1976, a comprehensive survey of environmental health programs in nine States was completed. Information from this study is being used to develop a strong technical assistance program for the Center during 1977.

During 1976, the Center, with assistance from a variety of camping organizations and camp safety officials, completed the development of suggested State statutes and regulations for youth camp safety. In addition, special health and safety standards for high risk activities in youth camps are also being developed. Health and safety standards will be expanded for several other aspects of camping and published in 1977.

Quarantine operations - Foreign Quarantine Regulations are being revised consistent with current scientific knowledge and medical expertise and the status of health in the worldwide community.

The revised Vessel Sanitation Inspection Program was implemented in 1976. CDC has assumed the responsibility for inspecting all passenger vessels arriving from foreign areas. Results of sanitation inspections indicate acceptance and compliance with CDC recommendations on the part of the passenger cruise industry.

Summary - Funds available in 1977 for this activity include a net built-in change of $1,503,000 for annualization of positions new in 1975, annualization of pay raises, within-grade pay increases, HEW Working Capital Fund, PHS Service and Supply Fund, Office of Federal Employees Health Benefits increases, FTS increases, postage and utility rate increases, partially offset by one less day of pay, and a program decrease in the amount of $1,503,000 resulting from reduced activities in surveillance of diseases such as cholera and plague; surveillance of rabies along the U.S.-Mexico border; sexually transmitted diseases other than syphilis and gonorrhea; and tuberculosis research.

Laboratory improvement

More than 4 billion clinical tests are done annually in the laboratories of this Nation. The accuracy of these tests determines, in many cases, the quality of diagnosis, preventive care, or treatment the American citizen will receive. CDC administers a multi-faceted program to improve the capability of the Nation's more than 14,000 clinical laboratories and to upgrade the quality of the tests and materials used by these laboratories. This is accomplished primarily through (a) technology development - a continual program of creation, refinement, application, review and appraisal of the laboratory tools needed for high quality clinical laboratory performance; (b) technology transfer - encouraging the application of effective procedures and materials to the tasks of the clinical laboratory.

To accomplish its objectives, CDC operates a national reference laboratory service and conducts extensive field and laboratory investigations. CDC provides assistance to laboratories of States, large municipalities, and, under the auspices of the World Health Organization (WHO), foreign countries in the form of consultation, laboratory management service, and dissemination of new and improved procedures. CDC assists in developing performance standards for commercial products used in clinical laboratories for the diagnosis of human diseases. Under the authority of the Clinical Laboratories Improvement Act of 1967 (CLIA), CDC is responsible for licensing and testing the proficiency of laboratories engaged in interstate commerce. In addition, it collaborates closely and extensively with the Social Security Administration (SSA) in developing uniform high standards for evaluating Medicare and CLIA laboratories. Other major functions include (1) providing extensive remedial short-term instruction programs in laboratory practice, with emphasis on helping State laboratories provide short-term training to clinical laboratorians; (2) conducting a long-term postdoctoral residency program in microbiology to develop broad competency in supervisory health laboratory personnel; (3) producing and distributing microbiological reference reagents for standardization and quality control purposes; (4) evaluating commercial reagents; and (5) distributing experimental vaccines and special immune globulins.

Specific activities for 1977 include:

1. Identification of Needs - CDC has found, over the years, that its programs of technology development, its contacts with State health laboratories, and its laboratory evaluation programs, including licensure and proficiency testing, have been able to effectively identify areas of need for technology development and training. The Center continues to expand its proficiency testing and on-site laboratory evaluation activities both in number of participating laboratories as well as numbers and types of constituents tested. Technical areas which are of increasing concern due to test volume and/or difficulty of tests performed and their clinical importance are emphasized. For 1977 some of these are: blood lead determinations, especially in children; blood levels of digoxin, a drug used in heart disease therapy, which must be continually monitored; alkaline phosphatase which is important in the diagnosis of bone, liver and prostatic cancer; and magnesium deficiencies which are of increasing clinical importance. In hematology, a new method for evaluating the technologist's ability to correctly read differential blood films will be employed. Review of the competency of cytotechnologists in screening vaginal and cervical smears for cancer will continue as will a survey of national competency in identifying carcino-embryonic antigen (CEA) in serum, a relatively new test used in cancer control. Findings from these activities will be directly applied to technology development and training activities.

2. Regulation - CDC has, since the passage of CLIA, utilized the regulatory process as one means of accomplishing laboratory improvement. Since that time, constant efforts have been made to meld the CLIA and the Medicare laboratory certification process so that the programs are uniform and non-duplicative. In the interest of economy and effectiveness and to insure maximum uniform coverage of the Nation's approximately 14,000 clinical laboratories, CDC has entered into an agreement with the Bureau of Health Insurance, Social Security Administration, and the Bureau of Quality Assurance, Health Services Administration which provides for an integration of functions. Bureau of Health Insurance will, through its State contracts, evaluate both CLIA laboratories and Medicare laboratories, with State examiners using the CDC-initiated standards and checklists. It will also provide for appropriate adverse actions against CLIA as well as Medicare-certified independent and hospital laboratories. The Center assumes the responsibility for oversight monitoring of the effectiveness of each State program and each surrogate evaluation program, including those of the College of American Pathologists, and the Joint Commission on the Accreditation of Hospitals. States will be expected to provide or approve a proficiency testing program equivalent to the performance evaluation program applied to CLIA laboratories. CDC will provide proficiency testing for CLIA and Medicare laboratories where States do not have equivalent programs. In the event that the monitoring program finds some part of a State evaluation program less stringent than that of CLIA, the Center will directly evaluate all Medicare and CLIA laboratories in that State until the State evaluation program can be upgraded. CDC will continue to initiate scientific and technical standards for application to both CLIA and Medicare laboratories in the areas of personnel, quality control, and proficiency testing.

3. Training - CDC has an active, effective, long-standing program of training directed toward areas which have been identified as appropriate high priority national needs. In 1977, the Center's laboratory training activities will emphasize support of State and local continuing education programs. Consultation will be provided to approximately 40 States in planning and conducting more than 100 courses for laboratorians with specific technical needs as determined by various laboratory evaluation programs. In addition, 50 on-site consultations will be provided to State health departments in organizing and improving their training programs. Another 1,000 supervisors with teaching duties will be trained in CDC headquarters courses which require expertise, equipment, and/or facilities not available in all States. These supervisors will multiply the technology transfer activities through direct instruction to their employees or involvement in State and local courses. As always, training materials developed at CDC will be available for use by any qualified public or private agency in its training activities.

4. State Assistance - Laboratory improvement is best effected by a combination of Federal, State (and local) assistance and motivation, utilizing the resources of private professional groups to the fullest feasible extent. In addition to the assistance provided to State continuing education programs, the Center continues to provide technical consultation to upgrade procedures used in State health laboratories in their roles as the first line diagnostic and reference laboratories in backstopping clinical laboratory operations. In addition, the Center will continue efforts to upgrade the capabilities of States to conduct laboratory improvement programs within their own borders. Such activities as on-site inspection of facilities and quality control practices, proficiency testing, technical consultation and remedial training

can best be accomplished by the States with support from the Federal government. Not only is technical and management consultation necessary to improve State programs but financial assistance is also imperative. This assistance would take the form of developmental assistance contracts.

Additional resources in 1977 includes a net built-in increase of $428,000 for annualization of pay raises, within-grade pay increases, FTS, postage and utility rate increases, partially offset by one less day of pay; a program increase of $4,034,000 which would allow the Center to carry out its responsibilities under the aforementioned agreement, including increased on-site surveillance of laboratories, provision of proficiency testing services to laboratories not otherwise covered and increased direct technical assistance in the development of State remedial training capabilities. The Center also would provide financial assistance in the form of developmental assistance contracts to States which have demonstrated a real interest in upgrading their intrastate programs. Such assistance, when extended to all States, would provide for the full gamut of laboratory improvement activities from regulatory monitoring to technical training and consultation designed to insure adherence by clinical laboratories to minimal levels of performance, regardless of size, type or geographical location.

Health education

Thousands of deaths and illnesses occur in the U.S. each year because the American people are not fully aware of the important role lifestyle can play in maintaining or harming health. Many premature illnesses and deaths can be prevented by decisions individuals can make to protect their own health.

To assure that all Americans can make informed health decisions, and to motivate them to take action to improve their health status, the Center for Disease Control provides coordination for a national health education program. The program encourages broad use of the Nation's health care system in its many ramifications so as to prevent unnecessary disabilities or death.

In 1977, emphasis will be placed by the CDC on coordination of health education activities already underway in various agencies of the Department of Health, Education, and Welfare. The CDC's role is not to proliferate health education programs or to establish unnecessary new activities, but to provide direction to and channel ongoing education programs so they will have the strongest possible impact.

Working through the Intra-Departmental Panel for Health Education of the Public, CDC's Bureau of Health Education will assure that appropriate attention is given to health education in all ongoing programs. It will establish a system for maintaining currency of health education activities throughout the Department. CDC will assist in developing guidelines to implement the health education priorities of the National Health Planning and Resources Development Act of 1974 and will intensify activities to assist HEW Regional Offices, other Federal agencies and State, local and private organizations to fulfill their health education responsibilities. To this end, the CDC will serve as a central source of information, expertise and referral in any area of health education.

During the next fiscal year the Center will develop effective health education approaches to specific health problems of defined target populations--the aged, youth and children, ethnic and linguistic minorities, urban poverty groups, rural poverty groups or those in special industrial areas--by initiating research, demonstration and evaluation projects. These will be designed to: (1) document the methods used in, and outcomes of, specific health education approaches; and (2) document criteria and methods for evaluating health education programs.

Research, demonstration, or evaluation projects will be carried out in cooperation with neighborhood health centers, schools, Agricultural Extension Services and other existing facilities which have demonstrated success. Other projects will involve initial programs with the newly formed "National Center for Health Education," comprised of private health groups, and the continuation of surveys of smoking prevalence among teenagers, adults, and health professionals.

The Center will provide health professionals, others who provide health services, and researchers, effective tools to assist in managing health problems related to smoking by: (1) compiling, producing, and distributing a desk reference containing a summary of the significant scientific evidence and health problems related to cigarette smoking and a bulletin containing the world's current technical information on smoking and health; and (2) initiating a system for periodically updating and distributing the desk reference and evaluating its use.

In 1977, the Center, through the National Clearinghouse for Smoking and Health, will collect, review and analyze more than 2,000 scientific articles to prepare the annual report to Congress on the Health Consequences of Smoking; it will distribute more than 10,000 copies of the Directory on Ongoing Research on Smoking and some 4,000 copies of a Smoking and Health Bibliography. It will continue to handle some 30,000 public inquiries related to smoking and health, though this system will be broadened through a project initiated to assist State and local health agencies in establishing and maintaining systems to respond to inquiries about smoking and health. Projects will be started with non-profit and private organizations to develop and implement new distribution systems for both general health and smoking education materials. These projects will involve the National Interagency Council on Smoking and Health (composed of the principal voluntary and professional organizations concerned with reducing death and disability from smoking), industrial communications organizations, and mass media organizations.

The collection and distribution of technical information, currently devoted primarily to the smoking and health problems, will be extended in 1977 to include other subject areas related to health education. In the Center's effort to improve the Nation's health by prevention of disease, health education will play a pivotal role by assuring that American people have information necessary to act in their own best interest.

A decrease of $500,000 results from a net built-in increase of $31,000 for annualization of pay raises, within grade increases, FTS increases, postage and utility rate increases and one less day of pay; and a program decrease of $531,000 in smoking and health education project evaluation.

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Occupational health:								
Grants	---	$1,900,000	---	$4,900,000	---	$1,900,000	---	-$3,000,000
Direct operations.	673	30,281,000	773	34,633,000	771	35,207,000	-2	+574,000
Total ..	673	32,181,000	773	39,533,000	771	37,107,000	-2	-2,426,000

The National Institute for Occupational Safety and Health provides the basic federal research effort to assure healthful and safe working conditions through: intramural research, research contracts, agreements with other federal agencies, and research training grants to qualified institutions. This research is directed towards the development of effective standards and work practices to prevent, avoid, and/or ameliorate unsafe and unhealthful working conditions.

Grants

Research grants are used to complement the research effort of the National Institute for Occupational Safety and Health. They provide research competencies from qualified institutions in certain fields not available within the Institute. Specific efforts will be directed toward NIOSH high priority areas, especially support of criteria development for standards or standards supplementation, occupational carcinogenesis, agricultural safety and health, and motivational and

behavioral factors research. It is expected that 34 research grants in the amount of $1,900,000 will be awarded in 1976 and 1977.

Training grants are used to support (at educational institutions) programs and curricula development designed to prepare qualified researchers, administrators, teachers, professional, and other practitioners, in all aspects of occupational safety and health subject matter. This effort is to aid in meeting the needs/demands of government, industry, labor, academia, and other sectors of society for adequate numbers of qualified people to accomplish the purposes of the Occupational Safety and Health Act. In 1976, it is expected that 50 training grants in the amount of $3,000,000 will be awarded to continue active grant supported training programs and initiate new grants.

The decrease of $3,000,000 results from the one-time funding in 1976 of the training grant program.

Direct operations

The National Institute for Occupational Safety and Health conducts research, develops criteria for occupational safety and health standards, and provides technical services to government, labor and industry, including training in the recognition, avoidance, and prevention of unsafe or unhealthful working conditions and the proper use of adequate safety and health equipment. These functions are designed to reduce the high economic and social costs of occupational illness and injury through the prevention and control of occupational diseases and hazards. They are authorized under the Occupational Safety and Health Act, Federal Coal Mine Health and Safety Act, and Public Health Service Act as amended.

The Institute's major continuing objectives and responsibilities are to conduct the research necessary to develop recommended occupational safety and health standards for submission to the Department of Labor, to set health standards for coal mine workers, to conduct industry-wide epidemiological studies, to stimulate occupational health and safety programs in State and local governments and in industry, and to provide technical assistance and training.

Currently, the most visible outputs of NIOSH are criteria documents transmitted to DOL, hazard evaluations performed, and persons training in occupational health and safety. The expected output in 1976 is to complete development of 24 criteria documents (this includes 16 planned and 8 that have slipped from previous years). It is anticipated that the number of hazard evaluations will be approximately 70 for 1976. The number of persons trained on a reimbursable basis will remain approximately 1,300 per year.

During 1976, the Institute will:

1. Complete development of 24 criteria for occupational safety and health standards including: sodium hydroxide, carbon tetrachloride, emergency egress, chromium (VI), oxides of nitrogen, and zinc oxide. It is anticipated that 26 criteria documents will be completed in 1978 resulting from the program increase in 1976.

2. Test and certify more than 100 protective devices and industrial hygiene monitoring devices;

3. Publish the sixth annual "Registry of Toxic Effects of Chemical Substances";

4. Provide response to an estimated 500 requests for autopsies of coal workers for research purposes and for establishment of survivor eligibility for Black Lung benefits;

5. Complete approximately 70 health hazard determinations in response to requests from employers or authorized representatives of employees for determination of whether substances normally found in their place of employment have potentially toxic effects;

6. Process approximately 17,000 coal miners' chest roentgenograms (X-rays);

7. Provide 1,300 man-weeks of training on a fee-for-service basis;

8. Define chemical or industrial processes which manufacture or use suspected carcinogens. There is a need to screen new chemicals before they become part of industrial processes and escape into the environment. New legislation, such as the proposed Toxic Substances Control Act, is needed to establish a system of pre-market screening of new chemicals.

9. Develop methodology for the acquisition and analysis of occupational data on a continuing basis for persons disabled by cancer.

10. Identify, through record studies, occupational groups associated with unusual frequency of cancer of specific organs.

11. Initiate 15 industry-wide studies which will include both environmental and medical epidemiological investigations. These studies will be conducted when there is evidence that a particular occupational group is experiencing an unusual rate of cancer, or when there is documented evidence of animal carcinogenicity related to a particular substance or agent found in the workplace.

12. Provide the necessary engineering control design technology for closed systems, ventilation equipment, etc., for the various work sites where carcinogenic substances are employed.

13. Provide the necessary development, review, and certification of respirators and protective clothing for workers employed in areas using or producing carcinogenic substances.

14. Provide for the necessary research in developing sampling regimens and analytical methods necessary to properly identify carcinogenic substances as well as providing for the methodology to monitor the work environment for carcinogenic substances.

15. Stimulate occupational health and safety programs in State and local governments, and in industries.

Some of the Institute's specific objectives for 1977 include:

1. Completing criteria of 24 hazardous substances or harmful physical agents including carbon dioxide, fluorine phosgene, phosphine, and zinc chloride. The Institute will continue to complete development of criteria documents initiated in 1975 and 1976;

2. Publishing the seventh annual "Registry of Toxic Effects of Chemical Substances";

3. Testing and certifying more than 150 protective devices and industrial hygiene monitoring devices;

4. Providing response to an estimated 500 requests for autopsies of coal workers for research purposes and for establishment of survivors eligibility for Black Lung benefits;

5. Completing approximately 70 health hazard determinations in response to requests from employers or authorized representatives of employees for determination of whether substances normally found in their place of employment have potentially toxic effects;

6. Processing approximately 30,000 coal miners' chest roentgenograms (X-rays);

7. Providing approximately 1,300 man-weeks of training on a fee-for-service basis;

8. Conducting industry-wide epidemiologic studies, research related to carcinogenic substances and other field studies. These include the North Carolina brick manufacturing industry study to evaluate the validity of "no disease" claims by the industry and the talc manufacturing study which includes tests to quantitate prevalence of chronic respiratory disease and lung cancer;

9. Stimulate occupational health and safety programs in State and local governments, and in industries.

The 1977 request provides for an increase over the 1976 request of $574,000 for mandatory items such as annualization of 1976 pay increase, annualization of positions new in 1976, within grade increases, postage increase, increase in utility rates, and an increase in the HEW Working Capital Fund and the PHS Service and Supply Fund. The decrease of 2 positions in 1977 are related to the elimination of the Training Grant Program.

	1976 Revised President's Budget		1976 Appropriation		1977 Estimate		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Buildings and facilities ..	---	$3,156,000	---	$4,612,000	---	---	---	-$4,612,000

The Buildings and Facilities Activity provides funds which remain available until expended for the construction, alteration and repair of buildings and facilities of, or used by, the Center for Disease Control, including the preparation of plans and specifications.

No new budget authority is requested in 1977. The $4,612,000 available in 1976 will be obligated during the year, resulting in a decrease of $4,612,000 in obligations in 1977.

In 1976 these funds will be used to plan a modern and safe facility at a suitable location for the research activities of the National Institute for Occupational Safety and Health.

	1976 Revised President's Budget		1976 Appropriation		1977 Estiamte		Increase or Decrease	
	Pos.	Amount	Pos.	Amount	Pos.	Amount	Pos.	Amount
Program management.	264	$10,989,000	264	$10,439,000	264	$10,989,000	---	+$550,000

The Center for Disease is the Nation's primary federal focus for an interrelated group of program activities directed at preventing diseases and their consequences. These funds will provide the executive direction and resource management staff necessary for planning, directing and evaluating all CDC program activities in 1977. The activities of the Center, being both national and international in scope, make it imperative that high quality staff support be maintained. These funds will enable the Center to fulfill its responsibility for proper stewardship of resources and to provide assistance and coordination to the Assistant Secretary for Health.

In 1977, the Center for Disease Control will continue to provide direct fund support and competent staffing to the ten Regional Offices. These offices will provide consultation, assistance, and services to State and local health agencies with respect to grant supported programs for disease control, rodent control, and prevention of lead poisoning in children, and serve as the focal point for the review of State plans and grants for the control of occupational diseases and work injuries.

The increase of $550,000 is for built-in increases for annualization of pay raise, within grade increases, and GSA rent; partially offset by one less day of pay.

Program Purpose and Accomplishments

Activity: Disease Control

1976 Estimate		1977	Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
2,617	$98,925,000	Indefinite	2,516	$95,197,000

Purpose: Title III of the Public Health Service Act. Preventing illness and maintaining scientific surveillance of diseases.

Explanation: The purpose is accomplished through project grants and a direct operation program aimed at investigations, research, and technical assistance to detect and prevent communicable and other preventable diseases or conditions. These activities are focused directly on the national goal of improvement of health care systems through emphasis on prevention rather than control.

Accomplishments in 1976: Epidemiologic assistance was provided to various State health agencies during the largest and most geographically widespread outbreak of St. Louis encephalitis (SLE) ever recorded; approximately 1.8 million different determinations were made on specimens submitted by States and local health department laboratories; and the Center provided coordination for a national health education program.

Objectives for 1977: Grants will continue to be provided to assist States and localities to develop control measures for a number of sexually transmitted diseases other than syphilis and gonorrhea because of their increasing national significance; to support immunization programs; rat control projects in communities with the most severe rat problems; and lead based paint poisoning programs.

Surveillance of diseases of national significance, such as hepatitis, influenza, and others will be continued.

The Center will continue to expand its proficiency testing and on-site laboratory evaluation activities both in number of participating laboratories as well as numbers and types of constituents tested. Efforts will also be aimed at improving laboratory surveillance and developing pharmacy surveillance in hospitals and clinics.

Coordination of health education activities already underway in various agencies of the Department of Health, Education, and Welfare will be further developed.

Activity: Occupational Health

1976 Estimate		1977	Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
773	$39,533,000	Indefinite	771	$37,107,000

Purpose: PHS Act as amended, Federal Coal Mine Health and Safety Act of 1969, and Occupational Safety and Health Act of 1970. This program is designed to reduce occupational illness and injury through the prevention and control of occupational hazards and diseases.

Explanation: Grants and direct operation funds are used to support research, training and technical assistance programs aimed at helping government and industry to administer occupational health programs, and to develop criteria for standards necessary for the successful implementation of a safe and healthful work place.

Accomplishments in 1976: (1) Thirty-four research grants in the amount of $1,900,000 were awarded in 1976; (2) fifty training grants in the amount of $3,000,000 were awarded to continue active grant supported training programs; (3) completed development of 24 criteria for occupational safety and health standards; (4) tested and certified more than 100 protective devices and industrial hygiene monitoring devices; and , (5) published the sixth annual "Registry of Toxic Effects of Chemical Substances".

Objectives for 1977: (1) Complete criteria of 24 hazardous substances or harmful physical agents; (2) publish the seventh annual "Registry of Toxic Effects of Chemical Substances"; (3) test and certify more than 150 protective devices and industrial hygiene monitoring devices; (4) provide response to an estimated 500 requests for autopsies of coal workers for research purposes and for establishment of survivors eligibility for Black Lung benefits; and, (5) complete approximately 70 health hazard determinations.

Activity: Buildings and Facilities

1976 Estimate		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
---	$4,612,000	Indefinite	---	---

Purpose: Title III of the Public Health Service Act. These funds are for construction, alteration, and repair of buildings and facilities including preparation of plans and specifications.

Explanation: Funds remain available until expended. No new budget authority is requested.

Accomplishments in 1976: A contract will be let for the plans and specifications of a modern safe research facility for the National Institute for Occupational Safety and Health.

Activity: Program Management

1976 Estimate		1977		
			Budget Estimate	
Pos.	Amount	Authorization	Pos.	Amount
264	$10,439,000	Indefinite	264	$10,989,000

Purpose: Title III of Public Health Service Act. This activity provides top management, staff services, and regional offices staff to assure the desired direction and development of the Preventive Health Services programs' goals and objectives. Rental payments for building space occupied by the Center are also provided by this activity.

Explanation: Executive direction of the various programs is strengthened by sophisticated planning and analysis in terms of mission accomplishment and managerial effectiveness. The regional offices assist and serve State and local health agencies and community groups in activities at the local level which are a part of national coordinated preventive health programs.

Accomplishments in 1976: The necessary staff was provided to assure policy and program leadership and to monitor and evaluate progress in achieving ongoing program objectives. Payments for the Center's occupied building space were made under the Standard Level User's Charge system.

Objectives for 1977: Effective and efficient program direction, staff services, and regional office support for Preventive Health Services programs will be provided. Payments of Standard Level User Charges will be met.

New Positions Requested

	1977		
	Grade	Number	Annual Salary
Disease control			
Laboratory improvement			
Hematologist	GS-15	1	$37,309
Chemist	GS-14	2	53,722
Public Health Advisor	GS-14	1	26,861
Education Specialist	GS-13	1	22,906
Public Health Analyst	GS-13	1	22,906
Microbiologist	GS-12	1	19,386
Chemist	GS-12	1	19,386
Mathematical Statistician	GS-11	2	32,510
Microbiologist	GS-11	2	32,510
Medical Technologist	GS-9	11	148,302
Microbiologist	GS-7	4	44,184
Cytology Technologist	GS-7	2	22,092
Histology Technologist	GS-7	1	11,046
Chemist	GS-5	3	26,775
Medical Technologist	GS-5	3	26,775
Laboratory Technician	GS-5	5	44,625
Microbiologist	GS-5	4	35,700
Secretary	GS-5	2	17,850
Clerk-Typist	GS-3	2	14,204
Total new positions, all activities		49	659,049

Transition Quarter Analysis

	Budget Authority by Activity	
	1976 Estimate	Transition Quarter
1. Disease control:		
a. Project grants	$41,400,000	$6,500,000
b. Disease investigations, surveillance, and control	43,411,000	12,380,000
c. Laboratory improvement	10,601,000	3,054,000
d. Health education	3,513,000	753,000
Subtotal	98,925,000	22,687,000
2. Occupational health:		
a. Grants	4,900,000	475,000
b. Direct operations	34,633,000	8,570,000
Subtotal	39,533,000	9,045,000
3. Buildings and facilities	4,612,000	---
4. Program management	10,439,000	2,800,000
Total	153,509,000	34,532,000

Explanation

The transition quarter budget represents funds to maintain the 1976 level of operation during the period July 1, 1976 - September 30, 1976. The total was based on 25 percent of the FY 1976 Budget Estimates.

SUBCOMMITTEE RECESS

Senator MAGNUSON. That concludes the hearing for today. I want to thank each of you for your appearance.

The subcommittee will stand in recess subject to the call of the Chair.

[Whereupon, at 4 p.m., Monday, February 2, 1976, the subcommittee was recessed to reconvene at the call of the Chair.]

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